the Canadian Nurse

VOLUME 58 • NUMBER 8

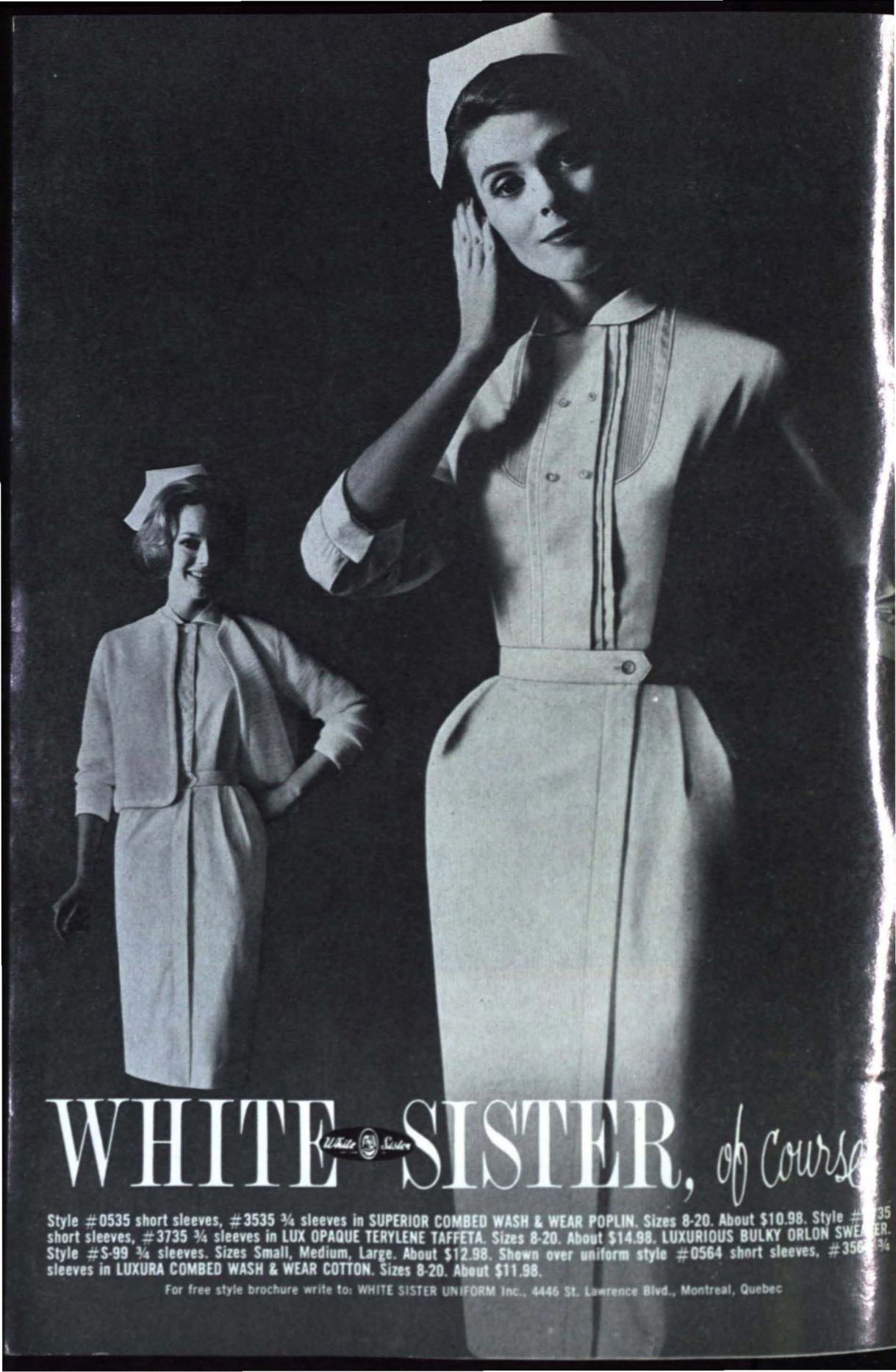
MONTREAL

AUGUST, 1962

HIGHLIGHTS

OWNED AND PUBLISHED BY

THE CANADIAN NURSES' ASSOCIATION



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Between Ourselves

The 1962 convention of the Canadian Nurses' Association will be discussed next month. This space has been reserved to give you a few of the highlights. Because newspaper coverage was only fair, even in Vancouver, you may not have learned the results of the elections. These are the officers for the ensuing biennium:

President: E. A. Electa MacLennan, Halifax. 1st Vice-Pres.: Mrs. Isobel MacLeod, Montreal. 2nd Vice-Pres.: Katherine MacLaggan, Fredericton. 3rd Vice-Pres.: Edna Rossiter, Vancouver.

The following members of the Nursing Sisterhoods were also elected: Sister F. Keegan, Montreal; Sister C. Leclerc, Calgary; Sister M. Mooney, Kingston; Sister Hugh Teresina, Glace Bay.

* * *

The most exciting development to come out of the convention was the announcement of the establishment of the CANADIAN NURSES' FOUNDATION. With the consent of the Executive Committee, the necessary application for the incorporation of the Foundation was made to the Federal Government. The result of the governmental approval means that nurses at last have their own Foundation to which donations may be made with income tax deductions and in which membership (also income tax deductible) can be held annually upon payment of a $2.00 membership fee.

The purposes of the Canadian Nurses' Foundation are twofold:

1. To provide bursaries and scholarships for nurses studying at the Master's and Doctorate level;
2. to provide grants for research in nursing service which may help to advance the knowledge and art of nursing.

During convention week a total of 140 nurses applied for membership in the Foundation. It is hoped that many thousands more CNA members will use the form printed below and become charter members of the Foundation. A membership card and the receipt for income tax purposes will be sent to you as soon as the applications are processed.

(Continued on Page 670)

APPLICATION

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(Provincial Association) (Number)

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(Signature)

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(Date) (Address)

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THE CANADIAN NURSE

VOLUME 58 **NUMBER 8**

AUGUST 1962

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

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The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

BETWEEN OURSELVES (continued)

A very substantial donation of $150,000 is being made by the W. K. Kellogg Foundation of Battle Creek, Michigan over the next six years. The first $15,000 that will be available this autumn will enable the Foundation to award a fellowship of up to $4,500 to one Canadian nurse for study at the doctorate level and in addition will provide for three scholarships of up to $3,500 each for those wishing to pursue work toward their master's degree. Each recipient will be required to pledge that she will return to Canada, if she should undertake study elsewhere, and engage in some branch of nursing activity. Because time is short before university classes commence this autumn, nurses wishing to make application for this monetary assistance are urged to write promptly to the Canadian Nurses' Foundation requesting an application form. A minimum of $30,000 will be available in 1963 and the following four years so members are urged to bear this in mind if they plan to study at either of the levels.

The Brief presented to the W. K. Kellogg Foundation closes with this comment:

> We believe that the leadership of the next few years must come from the well educated. In so far as academic degrees are the symbol of the educated, we believe that nursing leaders should match the symbols of the other educated professions in our social structure.

Demonstrate your faith in an investment in individuals by joining the Foundation now. Make it the primary objective of your annual donations to charitable organizations.

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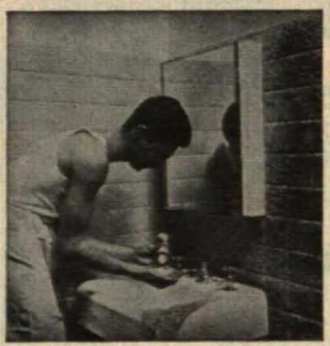

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AURORA ONTARIO

Random Comments

Dear Editor:

Thank you. Your article on Medic-Alert could not have been more timely.

My little boy recently was seriously allergic to penicillin and I have been on a search for Medic-Alert's address ever since.

I have placed the details in my doctor's hands for which he and his large clinic are grateful.

I am grateful too, to you, Mr. Finkle and Dr. Collins.

(Mrs.) MARGARET A. SODERBERG, Alberta

Dear Editor:

I would like to commend you for the excellent articles on evaluation, consultation, and motivation in the February, 1962 issue. The science of nursing is worthy of note. However, too often we sacrifice the human element for the more readily observed technical element. The amount of coverage you gave to this important area of nursing is worthy of praise.

ELEANOR M. CROSIER, San Francisco, Calif.

Dear Editor:

A small group of graduates from St. Eugene Hospital, Cranbrook, B.C. is endeavoring to organize a school reunion which will take place in 1963.

Will all St. Eugene graduates please write Sister Phillip Eugene, Superior, St. Eugene Hospital, giving her their addresses so that we may complete a mailing list for the invitations.

(Mrs.) ISABELLE KRAM, B.C.

Dear Editor:

May I take this opportunity to thank you and your excellent publication for the coverage you have given Medic-Alert. You may be interested to know that our office is delighted with the number of telephone calls and mail inquiries received, referring specifically to your highly thought-of magazine Your acceptance of our organization means a great deal to us, from a prestige point of view but it also lends authority to the educational program we are trying to do.

On behalf of Medic-Alert and everyone connected with the Foundation, thank you for your interest.

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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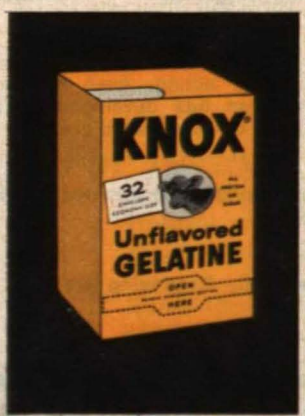

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- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September, 1957.
- ☐ 2. Derzavis, J.L. and Mulinos, M.G.: Med. Ann. D.C. XXX:133, March, 1961.
- ☐ 3. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March, 1955.
- ☐ 5. Tyson, T.L.: J. Invest. Dermat. 14:323, May, 1950.

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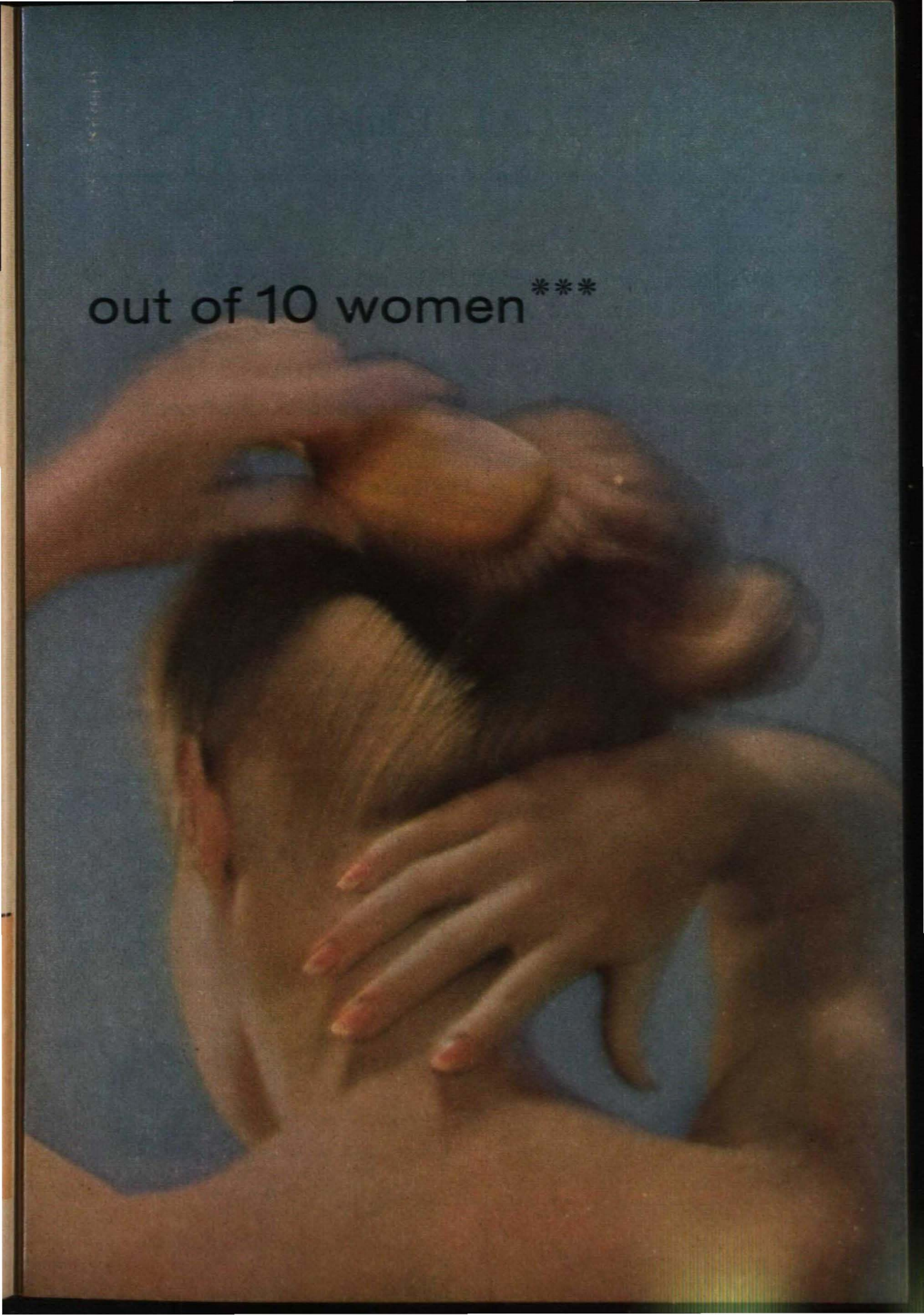
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Excerpt from "Meat in the Diet of Premature Infants," Sisson & Whalen, A.M.A. Journal of Diseases of Children, Vol. 95, Pg. 635. 1958. Available on request.

THE CANADIAN NURSE

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VOLUME 58 NUMBER 8

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PUBLIC RELATIONS – An Essential Activity

SOMEONE HAS SAID that a few men of the Renaissance were the last to know everything about everything. Since then knowledge (as distinct from wisdom) has increased so extensively and so rapidly that it is probably safe to say that nobody knows everything about anything. Ours is an age of specialization. Nursing itself is a specialty; so, too, is the practice of public relations.

Nurses have always practised public relations, good or bad; each one has had her own brand of "bedside manner." With the rise of other professions, all competing for a place in the sun, for recruits, for public understanding and appreciation, public relations for nursing has become more than an individual effort. It is now an essential corporate activity.

Public relations has been called many things. Charles W. Tisdall, consultant to the RNAO, has a favorite definition:

> Public relations is the art and science of gaining and sustaining public interest, understanding and approval for an organization, its people, its policies and activities. But, an organization with nothing to say in its favor cannot possibly benefit from public relations.

Convinced that the Association had

(Joseph Schmid)

JEAN C. WATT

much to say and only needs help to say it well, the RNAO has worked since 1956 in close consultation with the public relations counselling firm of which Mr. Tisdall is the senior partner. The program is not departmentalized or pigeon-holed in isolation. The RNAO retains counsel and, in addition, has designated one staff member to be responsible for certain duties. Both of these people work closely with the Committee on Public Relations. However, public relations permeate all activities of the Association. Counsel is available for consultation and assistance. All staff, in their specific duties in personnel relations, nursing education and service, registration and the rest, and officers and committees at provincial, district and chapter levels may call on this service for advice as to the methods that seem best for the particular project in hand.

One of the first activities undertaken following a study by counsel was to expedite communications and exchange of information throughout the membership — the Association's closest and, in many ways, most important public — at all levels and in all directions. The RNAO *News Bulletin,* now published bi-monthly, goes to all members. A special Memo from Headquarters, prepared by the executive secretary between issues of the *Bulletin,* carries important news to district and chapter officers and committee members so that they may be quickly informed and be able in turn to pass on the news to local members.

Institutes and workshops on RNAO business are convened from time to time at all levels with the result that more members are informed participants in Association affairs. Well-planned meetings are attracting greater numbers — meetings at which opinions are freely expressed, problems discussed and, sometimes, even solutions found.

In Ontario, where membership in the RNAO is voluntary, registered nurses may choose whether or not they will become members of their professional organization. Believing that to be informed is an important step towards understanding and support, the Association has a program of personal contact, invitation, education and persuasion which is a continuing activity. The aim of districts and chapters, through better communications and interesting activities, is to present the Association in such a light that registered nurses *dare not* remain aloof for fear they might miss something.

There is no real substitute for the personal contact of a well-informed nurse with the people she wishes to convince. But, with a rapidly increasing population, with so much to be told, other methods must be used if nursing's story is to reach other publics — high-school students, their parents and teachers, governing boards, employers, other professions and, of course, the general public. Here, the printed word comes into its own. Pamphlets and booklets about the organized profession, about nurses and nursing, have been prepared or are being planned, in the forms which will have the greatest impact on the groups to whom they are addressed.

One of the objectives of the RNAO, as stated in its letters patent, is "to render service in the interests of the public." This being so, it follows that recruitment is a professional responsibility to ensure that there are sufficient practitioners to render the service pledged. The Association makes use of different kinds of pamphlets. There are those for high-school students, both boys and girls, and for their parents. A recent meeting at provincial office of high-school guidance teachers and nurses indicated that counsellors would welcome information addressed especially to them to assist them in counselling students.

Public relations counsel, with its wide contacts and knowledge of the ways of wire services, newspapers, radio and television, has ensured that news stories about nursing are disseminated by methods not readily available to the Association alone. Communities like to hear about their own citizens and their doings. Wire services are invaluable when nurses attend meetings or conferences out of town; such news with names is of interest to local newspaper editors and readers. The public relations program has encouraged members to become acquainted with radio station managers. Members frequently appear on local

programs in connection with their meetings and special projects.

Through public relations counsel, the Association has been able to arrange a continuing series of spot announcements on radio and television in the interests of recruitment. Letters coming into provincial office indicate that these are influencing listeners to write for more information.

The program briefly outlined here is being conducted by the organized profession with special techniques, funds and staff and, most essential, with the wholehearted support and cooperation of the members who make up the Association. Everyone is engaged in the private practice of public relations. The registered nurse, skilled in professional duties, well-informed on nursing affairs, is still the best ambassador for nursing the profession possesses.

JEAN C. WATT

The Educational Needs of Handicapped Children

SAMUEL R. LAYCOCK, PH.D.

A discussion of some of the general principles that govern the education of the handicapped.

IN DISCUSSING the question of meeting the educational needs of the handicapped, what I have to say will be based on four basic principles:

1. That the education of the handicapped child can be most effective only when it is conceived on a broad basis as the interacting of the physical, intellectual, social, emotional, and spiritual aspects of his growth and development;

2. that the education of the handicapped must not be confined to the years normally devoted to school attendance but that it should be extended down into the entire preschool period and continue upward into adult years;

3. that the education of the handicapped child is always a partnership affair in which the active partners include his parents and age-mates, various types of his community teachers such as the church, health and welfare services and recreational agencies, and therapists and medical specialists, as well as school teachers and educational administrators.

4. that special education for the handicapped is an integral part of society's obligation to provide for *every* child — no matter what his capacities — an equal (and I mean *equal* not the *same*) opportunity to develop towards his maximum potential in the commonly accepted areas of educational objectives. These are: self-realization, human relationships, occupational competence and responsibility for others in home and community.

Let us now turn to what we can do to implement these principles.

To Realize Their Potential

In a democracy, social institutions — whether they be schools, hospitals, health services, welfare services or prisons — cannot be *much* better than the public opinion on which they rest. If that is so, one of our major jobs is to persuade the public that special education of the handicapped is not a hole-in-the-corner affair but an integral part of general education. Our grandfathers made a great step forward when they provided free compulsory education for all children. They thought they were providing equality of opportunity for all youngsters. This was a mistaken idea. What they actually did was to provide, to some degree (and only to some degree), equality of opportunity for average and superior children. Their job was incomplete. The handicapped children were kept out or pushed out of the school.

They were the forgotten children. Present-day attempts to educate the handicapped are part of the unfinished business of education. We still need to persuade the public to accept emotionally, as well as intellectually, the principle that *every* child — no matter what his capacities may be or what academic learning he is able to achieve — is entitled *as of right* to an equal chance to develop in accordance with his needs and towards a realization of his potential, whatever it may be.

Historically, the reaction of the public to its handicapped members has been marked by three stages. The first is fear, aversion and rejection; the second is pity; and the third, acceptance and understanding. Some individuals are still in the first stage; a great many are still in the pity stage; and an increasing number are progressing to the understanding and acceptance stage. We must hasten that development. Pity, by the way, is an overrated emotion. It usually lacks respect for the person pitied and is an unsatisfactory basis for human relationships. The public needs to emerge from the pity stage to one of acceptance and understanding. Only then can we be assured of financial provision for the education of the handicapped in terms of public policies, adequate facilities, personnel and equipment as well as an intensive research program.

In order to gain acceptance and understanding for the adequate education and treatment for the handicapped we need to convince the public of two seemingly contradictory principles: (1) that *all children are alike* and (2) that *every child is different.* By the point that all children are alike I mean that the public needs to see that handicapped youngsters are first of all *children* with all a normal child's physiological and psychological needs. The physiological needs are obvious even if we are still far from meeting them in adequate fashion. The psychological needs are, for example, those for affection, belonging, independence, achievement, recognition and a sense of personal worth. In general education, we have never been successful in convincing the public that the school must concern itself with meeting these emotional needs of its pupils. The public does not see that, even where the school's objectives are stated in the narrowest terms of intellectual development, such as the passing of examinations or the memorization of subject matter, the school has no choice but to be concerned with meeting the pupil's psychological needs. Otherwise, it is likely to be defeated in attaining its goals.

Many studies have shown that the frustrated and emotionally disturbed child cannot learn effectively. Both educators and the public are slow to learn the lessons which should result from the study of discipline problems, under-achievement, school drop-outs, and lack of creativity in pupils. We need to persuade the public to take a broad view of the education of the handicapped child — that his emotional as well as his physical and intellectual needs must be met, that he needs to be loved and treasured and to feel he is a desired and desirable member of his family and age-group; that he needs to do things for himself; that he needs to taste success, to win recognition and approval from others; and that all his learning will be contingent upon whether or not he feels comfortable about himself as a worthwhile person. To gain acceptance of a broad view of education of the handicapped is a tall order but a point of view for which we must continue to press.

The other point of view of which we must persuade the public is that *every child is different.* Again, in general education, we have had relatively little luck in getting the public to accept this, certainly at the elementary level. The public is inclined to think that good teaching will wipe out individual differences. On the contrary, it only increases them.

So far as handicapped children go, not only do they differ from normal children in their characteristics and capacities, but individuals suffering from the same handicap differ widely from one another even in the very characteristics for which they are being given special education. For example, in a group of trainable children whose I.Q.'s range from only 30 to 50, these youngsters differ significantly in their mental capacities and functions, not to mention in their personality and

physical characteristics. The same is true of any group of deaf, hard-of-hearing, partially-sighted, blind, crippled or emotionally disturbed children. There really is no such thing as a homogeneous group in special education. We must convince the public of this if they are to provide us adequately with skilled personnel, small classes and special equipment.

Finally, as a part of the idea that the education of the handicapped is part of society's job to provide an adequate opportunity for all its children to realize their potential, there emerges the principle that the education of the handicapped should be at public expense and not a matter of charity or voluntary effort. Only in the last century and a half has general education emerged as a public responsibility instead of as a private charity. Now, special education must follow the same road.

Early Identification

If we are to do our best for handicapped children we must discover them as early as possible and keep track of their progress. Since there are many types of handicaps and many multiple-handicapped children, there is need for a central registry under government auspices. We need adequate coverage by preschool clinics, school health services, and mental health programs. That Canada still has some way to go on this was seen in the report of Dean McCreary of the Faculty of Medicine of the University of British Columbia which he made to the first Canadian Conference on Children. The grosser defects in children are likely to be discovered early by physicians or public health nurses but this does not mean that there are adequate follow-up services even in these cases. When it comes to early detection of moderate defects, particularly in hearing, vision and mental development, or of the occurrence of emotional disturbance in children, these are only too often missed. What do we need in the way of adequate identification facilities and what are our present gaps in these?

Education in the Preschool Period

Many people are inclined to think that the preschool period is important only in providing physical care and treatment for the handicapped. Actually, those who have the responsibility of the education of handicapped youngsters are more and more concerned, in the care of these children, with the gaps that occur in their more or less informal but highly important education in their homes in their early years. We fail to realize the tremendous amount of education a normal child receives before he enters kindergarten or first grade. He has not only learned a language but he has developed the foundation for learning to read, to handle number relationships, and to understand the world of nature around him, as well as to mingle on equal terms with others of his own age.

Teachers of the handicapped at the school-age level have their problems increased by having to deal with pupils who come to them as deprived children and often as emotionally damaged children as well. Such youngsters often have two or perhaps three strikes against them. Our urgent need is to prevent this. This means pushing the idea of education (and here I use the term in a broad sense) down into the early preschool years.

What do I mean by "deprived" children? Many handicapped boys and girls are deprived of the experiences which promote the growth and development of the normal child. Teachers of the deaf and hard-of-hearing often find the teaching of language unduly difficult because the child has not had the basic language experiences at the time normal children receive them. The normal child is talked to and read to. He lives in a talking world. He has a chance to talk about his experiences. The acoustically handicapped child is apt to miss a very large portion of this — and at a time when the learning of a language is a normal procedure. This gap in his educational development is an almost irreparable loss. Provision should be made to give help to mothers so that they will take time to do deliberately what they often do unconsciously with normal children. Many don't realize that the deaf child needs to be talked to not less but more than the average child. Parents can be given help in one of several ways. One

is through home visits by public health nurses or specialists in the teaching of the deaf. A second is, as is now often done by schools for the deaf, the holding of institutes for the mothers of acoustically handicapped children. This may mean bringing the mothers and their youngsters to the school or to a convenient local centre where those trained in the education of the deaf may help them to see how they can give to their acoustically handicapped child a good deal of what they give to their normal child. It is not suggested that the mothers be made into teachers except in the sense that *all* parents are teachers. A third way is to encourage the use of correspondence courses such as those of the John Tracy Clinic. A fourth way, which is applicable to large centres, is the provision of day nursery schools and kindergartens. A fifth way which is more controversial is to accept deaf children into residential schools at an earlier age and place them in a primary or pre-primary unit. Aside from the above, a simple pamphlet made available to the parents could make practical suggestions as to how best they can help their child.

I have stressed what can be done in the preschool period for deaf children. The same principles apply in the education of children with other handicaps. The visually handicapped child needs help in getting, through sound, touch and taste, a range of experiences which the exploring normal child gets or is encouraged to get for himself. Similarly, the physically handicapped child is often a deprived child in his preschool period. Because of his lack of mobility his sensory and motor experiences may be limited. His social contacts with normal children and with adults are apt to be restricted. We need to explore ways in which we can help parents of such children to provide, in conscious fashion, a substitute for as many of the experiences of the normal child as possible. Again home visits by public health nurses, institutes for parents, simple suggestions in pamphlets, and periodic visits by mothers and their children to special treatment and training centres, are not beyond the realm of possibility in many cases.

Before I leave this emphasis on preschool education, may I give you one more example. Nolan C. Kephart, in his book *The Slow-Learner in School* (Chas. E. Merrill Books, Columbus, Ohio, 1960) points out that many slow-learning and educable mentally retarded youngsters find difficulty in learning to read because they have been deprived youngsters in their preschool period. He shows how ability to read rests upon a foundation of elementary sensory, motor and perceptual abilities. As an example of this, he cites the drawing of a square which is often used in reading-readiness tests for five-year-olds. In order to draw a square a child must first be capable of the gross motor activities which involve the large muscle groups of his body — the ability to sit up, to hold the head erect, to be able to sit on a chair, and to be able to move the fingers, hand, and arm in a coordinated fashion. In drawing the square, the child will need to have advanced from these gross bodily movements to specific movements of the fingers, movements which have to be controlled and integrated. This involves eye-hand coordination, the ability to distinguish between the two sides of the body and to control the two sides separately. It includes learning directionality, the ability to initiate a movement in a given direction and the ability to stop. Kephart goes on to discuss the use of form perception and temporal-spatial relations in drawing a square. He suggests that reading-readiness may need to be broken down into more basic skills and practice given in these. Further, he goes on to analyze the rather involved perceptual processes which are related to *space, time* and *meaning* which lie at the basis of learning arithmetic and other school subjects.

While a degree of physical maturity, which cannot be hurried, is necessary for the development of sensory, motor and perceptual abilities in the mentally retarded or other handicapped child, such a child is likely to be a deprived child even when he would ordinarily have developed these abilities. First, he is likely to be an emotionally damaged child due to the disappointment or rejection of his parents. This will interfere with the degree of learning which

would be otherwise possible. Second, just because he does learn slowly the handicapped youngster often has not had sufficient attention given to, or practice in, the development of these abilities. If he were spotted in the preschool period, his parents could be given some guidance in helping him to have at least an equal chance with normal children to acquire these basic sensory, motor and perceptual skills. Pre-kindergarten classes would also help.

Only too often we try to put a roof on the house without a sufficient foundation and superstructure on which to place it. With many handicapped children the preschool period is almost a dead loss. We must see that this is changed. This means more intensive study and research in the basic sensory, motor, perceptual and social skills which underlie a child's education.

Normal Contacts at the School-age Level

Where should the education of the handicapped take place at the school-age level? This education should, wherever possible, take place in regular classes in school. The children should be removed from such classes only to the degree to which the diagnostic team considers is essential for their best treatment and education.

For some time I have interested myself in the effects of isolation and segregation on various types of individuals. Two years ago, on the CBC radio network, I gave a series of talks on the effects of isolation on three groups — older persons, patients in mental hospitals, and prisoners in jails. My studies have led me to believe that isolation and segregation can result in considerable damage to the personality in terms of a feeling of difference and rejection as well as in various other ways.

We shall be able increasingly to devise ways in which many handicapped youngsters can, with profit, remain in a regular class. I have admired the provision of orthopedic, sight-saving, hard-of-hearing and other units in a regular class where often a single handicapped youngster and his teacher are given sufficient help by itinerant teachers and sufficient special equipment that he can remain with his normal age-mates. Certainly, the vast majority of emotionally disturbed and delinquent youngsters are likely to remain in a regular class even while being treated by a child guidance clinic or while on probation. With the provision of more training and help for regular teachers, and, if necessary, some special equipment many more handicapped children could remain in their regular class. One kind of help is essential. Both the principal and the classroom teacher must be helped to develop an objective and sympathetic understanding of the handicapped child and his needs. When this exists the pupils of the class and school as a whole will respond with attitudes and behavior that are devoid of pity, over-protection or rejection and they will share their activities with the handicapped youngsters as far as is practicable. The handicapped child will need help to accept himself and his limitations and to relate in wholesome fashion to his classmates. While progress has been made in keeping many handicapped in regular classrooms we can do better.

There will be many handicapped children who cannot be educated effectively in the regular class of the present size and as at present constituted. The first step to be considered in their removal is to a special class in a regular school. The special class for the educable mentally retarded is an example of this. However, every effort should be made to integrate the pupils of such a special class in the play, assembly, and other extra classroom activities of the school. Success in this direction is likely to depend on the attitude of the principal and the regular classroom teachers. When I started special classes for the educable retarded in Saskatoon 32 years ago, I went to great pains to develop an understanding and objective point of view in members of the regular teaching staff. One of my clichés is that "feelings are facts." They are often powerful facts in determining the success or failure of educational plans and procedures.

Where a special classroom in a school is not adequate for the treatment or training of the physically

handicapped child, efforts should be made to add a special wing to a regular school where special treatment facilities can be provided. In that case the children should be considered part of the school as a whole and as many contacts as possible with normal children should be provided. In some cases this can mean participation in assembly programs, intervisitation of pupils, exchange of programs and sharing achievements in art or handicrafts. Actually, being in a normal atmosphere where they can even *see* normal children has its merits. Some years ago at the convention of the Council for Exceptional Children at Cincinnati, I chaired a panel of parents of physically handicapped children. One mother of an intelligent crippled teenager told of how when her daughter reached her middle teens she asked to be taken to dances. She said, "I know I can't dance and I can't have a date but I want to be where other girls and the boys are." Later she was sent to a college for women. After a year she asked to be sent to a co-educational college. She said, "I know I can't have a date and can't marry but I want to be where the boys are." This seemed to be, in this girl, a healthy attitude. Certainly we must help most handicapped youngsters to adjust to the world of normal people and to be, as far as possible, a part of it, in spite of their limitations.

If the special treatment centre cannot be attached to a school, a day treatment and rehabilitation centre is the next step of removal from regular classes. In that event a great deal of imagination and systematic planning should go into methods of providing contacts with normal children and with the activities of the community. This takes time and energy but it is part of our job not only to help the child to continue to live physically but also to help him to live effectively and happily.

Only where treatment or training cannot be provided effectively in any other way should the handicapped child be isolated in a special residential school or hospital. Because of the very specialized services and equipment that are required it may be necessary to do this for a sizable number of handicapped children. This may include those who are severely disturbed emotionally, certain types of delinquents where specialized aspects of group living are required, severely mentally handicapped children, and various types of physically handicapped children where active and continued treatment is required. It may include, too, deaf, blind, and mentally retarded children from rural communities or from unsuitable environments. With the greater use of trained social workers and public health nurses, sufficient help may be given to parents and to the community that a considerable number of the handicapped who formerly were institutionalized may be able to remain in their own community. This should not be interpreted as my having, what my Scottish friends call, a "scunner" against institutions. In many cases they are the only wise answer to the problem of a handicapped child. However, even where the child is in a residential institution, every effort must be made to provide him with as many contacts with normal children and normal community activities as possible.

Decisions by a Team

Decisions regarding the education of a handicapped child should be made by a dignostic team which definitely includes educators and teachers as well as speech therapists, occupational and physiotherapists. I would on many occasions include parents for they are also important members of the team.

For a long period decisions as to the training and education of the handicapped were almost exclusively in the hands of the medical profession for they were the only trained professional people available. Now, with the growth of trained personnel in the fields of nursing, psychology, social work, education and speech, occupational and physical therapy, and with the rapid expansion of knowledge, no one group can go it alone. May I make a plea that among the trained personnel of the diagnostic team there be a line-relationship rather than a hierarchy where many members of the team are in a distinctly subordinate position.

In particular, I would like to make a plea for admitting educators, teachers

and principals to the planning for a handicapped child's education. Being merely told *what to do* does not involve them in a way which will produce the best results in intelligent cooperation even if they do not subconsciously drag their feet by a feeling that their own knowledge and experience has not been used in adequate fashion. After all, most teachers — even the average ones — of necessity learn a great deal about children just from being with them for years on end. They not only learn about individual children but about children in general, especially about their different responses to a variety of learning and environmental situations.

What Kind of a Teacher?

The careful selection of the teacher of handicapped children is exceedingly important. And by teachers I mean all those who participate in the rehabilitation of these youngsters — not merely the academic teachers — but the physical, speech and occupational therapists; the nurses; child care attendants; cooks, kitchen, dining room and house maids, and janitors. If learning takes place whenever behavior is modified then all of these persons may affect the learning of the handicapped child and are, to that degree, his teachers. I recall, during the last war, visiting a centre for the rehabilitation of psychoneurotic soldiers. The superintendent, a very wise psychiatrist, said: "The woman who cleans the front steps is a part of my treatment team."

What kind of personnel, then, are desirable to teach handicapped children? At the head of the list I would put the selection of people who feel reasonably comfortable about themselves and secure within themselves. Certainly, I would exclude those who use their service to these youngsters as a means of satisfying their own neurotic needs for over-domination, or over-protection or for draining the emotional reserves of the child. I have long felt that the term "common sense" had only a fair correlation with intelligence. I suspect it has a high correlation with the individual's mental health and his state of emotional well-being. So the teacher of the handicapped must be, first of all, a wholesome person able to take an objective yet sympathetic view of the problems of the handicapped.

I would like, too, to have in such a teacher what I call "emotional imagination," the ability to have sympathy with the child — to some degree to be able to sit where he sits. Not all people of high intelligence, academic achievement, or even of considerable training have this characteristic.

While I consider above-average intelligence very important I am even more interested in *creative* individuals. A great deal of attention is presently being given to the study of creativity — what it is and how it may be fostered. The creative individual is one who is keenly sensitive to problems, who is flexible in his thinking, who has a fluency of ideas, who is spontaneous and who can take off from a stimulus rather than merely latch on to it. Teachers of the handicapped must do creative teaching. They must be resourceful enough to devise and alter methods of teaching and materials so as to meet the needs of the individual child as the occasion arises.

All this does not mean that I do not stress training. Quite the reverse! The right person thoroughly trained for the job is the ideal. To thorough training I would add an eagerness to continue to grow by reading, study and experimentation as well as by taking refresher courses. I am afraid of the teacher who has "finished" his education. He has no place in our modern world of rapid change and exploding knowledge.

I shall not discuss the important question of curricula for the handicapped. Here, I feel, we need a great deal of research to discover just what curricular materials and methods of teaching will help different types of children — and in the last resort, individual children — to reach their potential in the general areas of self-realization, happy human relationships, occupational competence and citizenship in home, school and community. We need intensive study and research in order to be able to spell out what these mean for the various groups such as the trainable mentally retarded, or the blind, the deaf or the orthopedi-

cally handicapped child. To use one example, what does development towards occupational competence mean? Is it more than academic training or training in specific skills? Does it include the abilities to get on with others, to stay with a job, to persist at a task until it is finished, to get to work on time, to do the best job possible and to observe safety precautions? If so, vocational training starts in the preschool and early school periods.

We need a fresh approach to the question of what to teach to handicapped children. Too often we merely make use of a slowed-up or watered-down version of the curriculum for average youngsters. Teachers of various types of the handicapped need on-going committees to make intensive study of what should be taught to their type of child. In addition we need funds set aside for systematic educational research in curricular material and, in particular, into how handicapped children learn. Recently, for example, a special education monograph by C. Orville Johnson and Kathryn Blake called *Learning Performance of Retarded and Normal Children* (Syracuse University Press, 1960) indicates that several of the commonly held ideas of how retarded children learn may not be true.

We need to know more about how physical, social, emotional and intellectual factors interact with one another, in the learning of a handicapped child, and how these factors may mutually reinforce or frustrate each other. This, too, is a team job.

I close with an appeal for a concerted effort to have research funds provided in the educational field as well as in the physical field of the handicapped. We are at a point where we need more exact knowledge of how to meet their educational needs.

MUSCULAR DYSTROPHY

MARY ANN WHITEMORE

Did you know that an estimated 10-20,000 people in Canada have muscular dystrophy and that the majority of these are children?

MUSCULAR DYSTROPHY is a progressive wasting and weakening of voluntary muscles until the patient's body is useless, though the mind is still alert. In the pseudo-hypertrophic type a family history of the disease is often obtained. Isolated cases occur but often several children in each generation contract the disease. Males are affected more often than females in the ratio of three or four to one. The males who escape beget healthy children while the females may transmit the disease; thus it is sex-linked as is hemophilia and color blindness. Usually, the earlier the onset, the worse the prognosis. It is commonly manifested between five and eight years of age or in the transition between infancy and childhood. Often puberty and adolescence seem to bring it into the foreground.

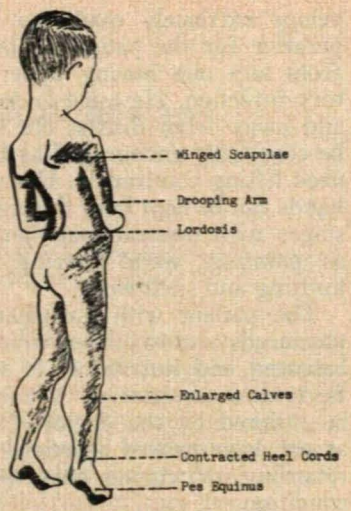
In the other main types of muscular dystrophy isolated cases are rare. Usually, several family members of both sexes are affected in the same and in succeeding generations. The age of onset is any time between infancy and old age. Various types may affect members of the same family. Age of onset may also vary.

The signs and symptoms of the pseudo-hypertrophic form are often so insidious that the parent may fail to notice them for quite some time. There is enlargement of the calves and weakness in the muscles of the pelvic girdle. The buttocks, quadriceps, deltoid and triceps are often hypertrophied. The child often looks strong with "developed" muscles but is actually quite weak. He cannot run and skip as other children do. There is great difficulty in climbing stairs and the child seems to pull himself up by the use of his arms. The child often

trips or stumbles, falls and gets up in a unique way, peculiar to the disease. He turns over on to his hands and knees and assists himself to stand by clasping his legs with his hands and climbing up his own legs. Lordosis or swayback becomes obvious and the child throws his head backward and abducts his arms for better support. This achieves a typical waddling gait. The child's arms seem to drop due to poor fixation of the scapulae which protude like wings. As the disorders progress, weakness increases. Muscles of the thigh, shoulders and arms seem to fall away from the trunk although the calves and forearms retain their normal or enlarged contours. Often the child's hands retain good power until the end. Contractures of the calf muscles may cause the feet to develop *pes equinus* so that the patient walks on his toes. Later, the sole of the feet arch and turn inward. The child is unable to walk.

In the Leyden-Mobius type, hypertrophy is absent and the wasting predominates in the lower limbs. In the Landouzy-Dèjerine (or facioscapulohumeral) dystrophy, onset is usually in late childhood. Lordosis and scoliosis are prominent. The muscles of the shoulder girdle and upper arms become weak and are soon wasted. The face has a characteristic "flat" smile. The facial muscles are quite weak and the patient is unable to whistle. The lips are habitually separated and the lower lip projects in a pout. The eyes are incompletely closed in blinking and when the patient tries to forcibly close his eyes or lips they can still be opened easily. Deformities are neither as common nor as severe as in the pseudo-hypertrophic form. There is no pain involved in any type.

The diagnosis may be difficult to obtain unless the doctor takes a very careful history. Thaddeus Danowski stresses that while symptoms of gradual onset, symmetrical involvement, slow inexorable course without remissions, and freedom from subjective sensory disturbances are present in every patient with muscular dystrophy, these symptoms may also characterize intrinsic disease of the nervous system. Existence of substantiated muscular dystrophy in brothers and sisters or other relatives may be a helpful clue in diagnosis. Physical examination should reveal symmetrical muscle weakness, diminished reflexes, a waddling gait, difficulty climbing stairs, inability to rise from the floor without climbing up the legs (Gower's sign) and later on, contractures. Spinal fluid examination is normal. Decreased bone density, caninization (increased vertebral height), scoliosis and lordosis are often present. Hypercreatinemia and excessive creatinuria are found in advanced cases. Serum calcium and phosphorus levels are somewhat high. A lowering of the mean values of chloride and cholesterol is found together with increased alpha globulins and alterations in gamma and beta globulins in serum. There is an elevated serum protein-bound iodine although disposal of thyroxin is normal.



Moderately Advanced Pseudohypertrophic Progressive Muscular Dystrophy

The unfortunate child with muscular dystrophy cannot be cured but physiotherapy helps to prevent contractures and prolongs the use of the muscles. Walking should be practised as long as possible and exercise should be both passive and active. Massage may also help in prolonging muscle use. Use and care of braces and wheel chairs is taught by the physiotherapist.

The nursing care consists, in far-advanced cases, of taking care of a helpless patient confined to bed. He must be bathed in bed and turned at least every hour day and night, oftener if possible. Pneumonia de-

velops extremely easily so it is imperative for the patient to be isolated from any one having upper respiratory infection. He must be kept warm and away from drafts. He must also be constantly encouraged as his spirits need lifting continually. His mind and hands can be kept busy during the later stages with occupational therapy such as painting, wood carving, reading, knitting and shell work.

The patient with muscular dystrophy needs a normal diet which is well balanced and nutritious. It should be fairly low in calories. Vitamins may be ordered by the doctor. No drugs, as yet, have proved beneficial in either retarding or curing this destructive condition.

Very little is known about this crippling, killing disease, yet it wasn't until 1953 that an organization was formed to devote all of its time to research. The Muscular Dystrophy Association of Canada is a national nonprofit health association dedicated to finding the cause and cure or effective treatment of this disease. Current membership is about 15 thousand. More than 80 per cent of the annual budget goes into research. Its only source of funds is public donations. It has 24 research projects now underway in university centres across Canada. The M.D.A.C. also supports research projects in medical institutions abroad. It has voluntary work organized into local chapters to give comfort and advice to patients and their families. It helps to establish clinics, provide transportation to and from schools and clinics, supply wheel chairs, lifts, braces and other orthopedic devices and actually defray medical and hospital expenses where the circumstances indicate the need. The Association also provides research fellowships for young medical graduates and summer fellowships for medical students. Funds are needed to carry on this outstanding program.

In 1954, the International Association of Fire Fighters and their locals resolved to support the Muscular Dystrophy Association's fund-raising campaign until a cure was found. Usually each November, fire fighters make door-to-door fund-raising marches and are helped by the Boy Scouts and other organizations. They place cannisters for donations at various places in the community. The firemen also help organize local mailing campaigns and allow their fire halls to be used as receiving stations for gifts. Some make speeches on behalf of the Association and participate in other publicity efforts and appeals. They form a vital part in the fight against muscular dystrophy.

The prognosis for pseudo-hypertrophic muscular dystrophy is grave — usually most die within ten years. But, for the other types, progress of the disease is varied and death usually results from complications of an upper respiratory infection or aspiration as the muscles are too weak even to sneeze or cough.

Let's not let these children die!

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REHABILITATION

The Coordinating Council in Saskatchewan

HESTER J. KERNEN, M.A.

The concept of rehabilitation as an important phase of comprehensive patient care has been accepted by all of the health professions.

A SURVEY OF professional journals and of the programs of meetings and institutes reveals that much attention is being given to the topic of rehabilitation. Emphasis is placed on the need for a wide range of services and a variety of professional skills in carrying out an effective program for the patient, regardless of the type of disease or accident from which he suffers. The phrase "team approach" is used to describe a basic attitude toward shared responsibility and interdisciplinary communication that promotes good coordination of effort among the team members and provides both quality and continuity of care for the patient.

However, the team approach becomes more difficult as the patient moves out from the hospital or rehabilitation centre into the community and the lines of communication are lengthened. Although there has been a rapid development of the services necessary for restoration of the individual to his home, to a job and to social and recreational aspects of community life, this development has been uneven. Some gaps exist especially in relation to certain age groups or diagnostic categories. Other services that are becoming available may not be well known and the individual is not referred for the assistance that he needs. As a result of the interest of many people, involved either as professional workers or as citizens in education, health and welfare services in their communities, and further as a result of their awareness of problems in planning and coordination which might be amenable to joint action, a new organization has been at work in Saskatchewan for the past two years.

The Coordinating Council on Rehabilitation for Saskatchewan was organized in January 1960 with representatives from all groups who share a concern about handicapped persons. Its aim to provide a channel through which voluntary agencies, government departments, and professional associations can work together to strengthen rehabilitative services for patients in hospitals and in the community. Any agency providing such services in Saskatchewan, or interested in them, can become a member of the Council. There are now over 50 groups participating.

Voting delegates and other representatives from member agencies meet at the annual congress and, in addition, may take part in a number of other activities and projects directly related to improving rehabilitative services. Doctor G. Allan Roeher is the Executive Officer. His services were made available to the new organization by the provincial government since it was felt that this responsibility could be carried without conflict with his position as Provincial Coordinator of Rehabilitation. The Executive Officer and his staff act as an information centre and clearinghouse for the member agencies. In this way assistance can be gained in solving problems and in avoiding gaps in services.

The interdisciplinary nature of the organization perhaps can best be illustrated by noting that the 17-member board of directors includes directors of voluntary agencies, social workers, teachers, a physiotherapist, a nurse, a clergyman, a hospital administrator and physicians from the specialities of internal medicine, physical medicine, pediatrics and psychiatry.

The Council assists its member agencies in the following manner:

1. By serving as a clearinghouse for information and case referrals;
2. by assisting in the development of special projects that strengthen member

agency programming, e.g., refresher courses for professional staff, surveys of problems;

3. by alleviating the problem of acute shortages of professional staff via career development programs and the operation of a professional personnel bureau;

4. through the development of a system of objective program analysis, for example, the case closure statistical system;

5. by encouraging agencies to utilize special monies available for special program purposes;

6. through public education programs on rehabilitation and provision of information about agency services;

7. through inter-agency information services;

8. through the development of long-range plans or a blueprint for rehabilitation programming in Saskatchewan;

9. by providing assistance in solving problems and in the development of new programs;

10. through coordination of existing services.

A major project of the Council has been the preparation of a directory of educational, health, welfare, recreational and rehabilitative services in Saskatchewan. The initial distribution of this publication was made without charge to a wide selection of agencies and individuals. Copies are available at a nominal charge. The directory was designed as a reference guide and contains information about services under both the subject and the name of each organization. Subject matter is extensively cross-referenced for ease in use. There is space in each section for personal and local addresses and provision is made for changes and additions to keep information up-to-date. From the point of view of nurses this seems to be the kind of reference tool that is frequently needed in planning continuity of patient care. It gives the answers to such questions as "Is there a service to meet this family's needs?" and "How do I get in touch with the people operating the service?"

Another important activity of the Council has been the preparation and presentation of briefs to the Advisory Planning Committee on Medical Care, which presented an interim report to the government of Saskatchewan in late 1961, and to the Royal Commission on Health Services which has been holding public hearings across Canada during the past months. In both presentations strong emphasis was given to the need, in extending health services, to ensure a comprehensive and well-coordinated program for treatment and rehabilitation of persons mentally and physically ill. Attention was drawn, also, to the need for utilizing and strengthening the contribution of voluntary agencies, and to the value of such services in complementing the programs of official agencies.

A great many of the activities of the Council are carried on by the members of its five divisions and their subcommittees. The size of these committees has been limited so that they may function effectively as working parties. Members have been appointed because of their special knowledge or ability to contribute to the solution of problems. Within these limitations the committee memberships are inter-disciplinary. Nurses are contributing to the work of a number of the committees.

The Special Education and Training Division and its sub-committees have been studying the matter of teacher recruitement and training for work with educable mentally retarded children of senior age and the extension of opportunities for these children. In addition, it has concerned itself with the upgrading of present personnel who have insufficient education and training.

The Research-Consultation Division established three *ad hoc* committees to work on areas of particular importance. The Regina Vocational Survey Committee planned and executed a three-month survey in that city during the spring and summer of 1960. The survey had two major objectives:

a. To determine the number and nature of employment opportunities for the handicapped of the area;

b. to determine the volume and variety of subcontracts which might be obtained by sheltered workshops in the region.

A Disability Registry Committee was set up to study the principles and mechanisms involved in operating a Central Index or Registry of Disability. A Program Evaluation Project Committee is also active. It is felt that

the Research-Consultation Division could be of assistance in recommending appropriate topics of research to areas, groups or individuals so that activities would be complementary rather than duplicated.

The Psycho-Social-Vocational Division has been active in making preparations for the National Conference on Sheltered Work which was held in June, 1962. An Interprovincial Rehabilitation Counsellor Training Institute was held under its guidance in 1961. Active subcommittees in this Division are the Recreation Committee, the Committee on Accommodation for the Handicapped, and the Committee on Employment of the Disabled. The Division has been closely associated with two projects — the Holiday Home for Crippled Children and the Proposed Regina Home Care Program.

The Medical Rehabilitation Division and its three committees have accomplished much during the past year. A brief on Geriatric Rehabilitation was presented to the Aged and Long-Term Illness Survey Committee of the Saskatchewan government. A nursing care routine for severely disabled patients has been devised, and is now undergoing trial in hospital and geriatric settings. Other activities included the distribution of information on geriatric rehabilitation and a consideration of rehabilitative programs and discharge policies in geriatric centres.

The Prosthetics Committee has concerned itself with the development of prosthetic services. It has had joint meetings with the Saskatchewan Council for Crippled Children and Adults and with representatives from the Department of Veterans Affairs.

The Speech Therapy Committee concentrated on development of a summer speech therapy program. This project was proposed to the Junior Red Cross which agreed to sponsor it in the summer of 1961. The program was conducted for six weeks in the Humboldt-Wadena Health Region, under the direct supervision of the Regional Health Officer and with a staff of a psychologist (part-time) and two speech therapists (full-time). The activities consisted of diagnosis, assessment and counselling among speech-defective children in the Health Region. Some consideration is being given to a similar project for 1962. The Division has assisted the various professional organizations in promoting several highly successful refresher courses for nurses and physiotherapists respectively.

The General Administration Division has specific responsibility for public education, and for studying problems related to the supply of qualified personnel for rehabilitative services of all kinds. A Rehabilitation Personnel Bureau is being operated to serve as a clearinghouse through which job seekers may obtain information about vacancies in Saskatchewan and through which agencies may contact available personnel. A career development program has been devised to give information to and promote interest among high school students. Recommendations regarding training assistance have been made to appropriate departments of government.

In regard to public education an Employer Recognition Project has received a good deal of attention. At the second Annual Congress in Saskatoon last year three firms were cited for the outstanding contribution they had made in giving employment to the handicapped. The awards, officially known as the Lieutenant-Governor's Citation, were presented by His Honor F. L. Bastedo, Lieutenant-Governor of Saskatchewan. In addition to giving recognition to the enlightened employment policies of such firms the annual awards also point up the important contribution that rehabilitated persons can make as workers.

The diversity of the activities mentioned undoubtedly gives an impression of a complex organization which could become unwieldy. The Council has been concerned that it should be a flexible instrument that will be useful to its member agencies rather than "just another association." It is believed that setting up active working committees to deal with specific problems is one means of directly involving members. At the annual Congress provision is made for discussion of problems brought forward by agencies. Another method of promoting flexibility is the plan that has been adopted by the board of directors that provides for an

evaluation of the Council by its member agencies. This was carried out by Doctor Robin F. Badgley, a medical sociologist on the faculty of the Department of Social and Preventive Medicine, University of Saskatchewan. His report and its implications were discussed freely at the second annual Congress. Although general approval of the Council was expressed by the member agencies, there was no lack of constructive suggestions for future activities. A number of these are already underway. In this atmosphere and with the continuing enthusiasm of its member agencies this cooperative approach is benefiting rehabilitative programs and agencies in Saskatchewan through: Improved quality of services; decreased program costs; decreased administration costs; better utilization of available funds; balanced program development; expansion of many services; increased public confidence in and support for the agencies concerned.

REHABILITATION

BARBARA BYCROFT

A student nurse presents her point of view.

TO BE ABLE TO clench both of my fists, to enjoy the stretching of my leg muscles as I climbed up the steps to the residence, to turn my head and look back at the hospital as I opened the door, these movements were vitally important to me. I was particularly conscious of them because I had just seen the amputation of four-year-old Donald's left arm. As I observed the surgical procedure, I realized with shock the adjustment to everyday living that this little boy would have to make. Now he had only one hand — one hand to button his shirt, tie his shoes, catch a ball, make snow-balls.

Rehabilitation! How often reference is made to this process! Although we speak of it frequently, few of us really understand its full significance in nursing care. Our reliable friend, the dictionary, suggests that rehabilitation is "the restoration to former rights." Restoration refers to "a process of rebuilding, of healing, of putting a person into his or her former place."

It is each individual's right to enjoy independence within his own limits, to exercise it to his fullest capacity, to be satisfied with nothing less. This concept seems most pertinent in understanding the meaning of rehabilitation. If a person becomes incapacitated to any extent, it is certainly a threat to his independence, his self-sufficiency, and perhaps even to his individuality. If such is the case, then it is the individual's right to find the means to regain independence and to adapt to his circumstances. In this attempt at adjustment, he would regain independence within the limitations that are peculiar to his own situation.

It has often been suggested that a person never realizes what is really his until he loses it. When the loss occurs, qualities may develop within the person that were never evident before. There may be a great need in him to be free of the help of others, to be free of pity. This takes courage and determination. However, for some this need is not present. Human nature is such that illness, despite its attendant discomforts, can assume an attractive status, with complete relief from responsibilities. Because of this, the nurse is not only responsible for carrying out a teaching program so that her patient may learn how to adapt to his new situation, but she must be able also to instil hope, the will to care, the desire to achieve independence. She must be aware of the importance of emotional factors, such as fear and anxiety. They can restrict the patient's cooperation and limit his motivation for recovery.

"Any therapeutic program must anticipate the eventual restoration of maximum function and efficiency, and be designed to accomplish this objective with a minimum of delay.*" The principles of a rehabilitation program should encourage each patient to establish the earliest possible self-care. The new mother in the obstetrical ward, for example, is involved in such a program. Her nurse tells her that she may get out of bed, that her doctor has allowed her "to be up and about." She is gradually regaining her "former rights," she is able to begin "self-care." But her nurse must realize that this restoration can not be accomplished just by conveying the news "you may get up now." She must evaluate her patient's needs; realize the extent of encouragement and help that she must offer in order to assist her patient to take the first steps towards self-care. This applies to any patient, no matter what situation is peculiar to him.

The definition of rehabilitation includes "restoration to a former place." "Former place" suggests the home and community. An important part in the nurse's guidance of her patient as he regains his independence and makes his adjustment, is to prepare him for his return to the community. Emphasis should be placed on activities of daily living. In considering our patient's return to his "former place," it is important to give explicit instructions that indicate activities which he may or may not perform.

The family, too, should have a good understanding of the capabilities of the patient. Many times this includes an explanation by the physician of the disease process and of the eventual outcome. The family must realize the importance of allowing the patient to exercise his right to independence, in spite of occasional discouragement and impatience. The patient and his family should be introduced to any community agency which will sponsor him in his rehabilitation program, financially or otherwise.

Working among handicapped people, one often discovers great courage. Rejecting pity, disabled people may continuously demonstrate their powerful urge to become self-sufficient. I have discovered many things about the meaning of rehabilitation. I have come to realize that every patient must be allowed the right to show courage, to reject pity, and to be self-sufficient, to have self-respect and independence, both in hospital and in his former environment.

*Emerson, C. P., Bragdon, J. S. *Essentials of Medicine.* Ed. 18 Philadelphia: J. B. Lippincott. 1959.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — AUGUST 1922)

A resolution proposing that conventions of the national association be held biennially instead of annually was approved by a vote of 113 to 11.

* * *

In a discussion of the relative merits of having single rooms or open wards in the hospital, it was pointed out that, following present day advancements in medicine, it was necessary to give much greater attention to each individual patient, his diet and various treatments. It was agreed that a much larger nursing staff was required where any considerable number of single rooms existed. The C.N.A.T.N. gave approval to the provision of general ward care for the majority of patients with single rooms for special cases only.

* * *

A resolution proposing the appointment of a full-time secretary to the national association and the opening of a national office was approved. The Canadian National Association of Trained Nurses has some 10,000 members.

* * *

The Toronto General Hospital has set junior matriculation as its entrance requirement for all young women wishing to train as nurses.

NURSING PROFILES

This month the New Brunswick Association of Registered Nurses welcomes **Anna Archibald Christie** to the staff as educational consultant for the province's schools of nursing. Born in Landsdowne, Pictou County, N.S., the daughter of a clergyman, Miss Christie lived in three of the Atlantic provinces at various times before coming to Quebec and the Montreal General Hospital for professional preparation. Her earliest education was obtained in schools on "The Island" and in New Brunswick. Later she studied at Prince of Wales College, Charlottetown and completed this phase of her career by obtaining her teacher's license.

ANNA CHRISTIE

Following her graduation from M.G.H., Miss Christie enrolled in the McGill School for Graduate Nurses and obtained her certificate in teaching and supervision in 1943. In 1955 she completed the requirements for her bachelor of nursing degree from McGill, majoring in administration in hospitals and schools of nursing. Since that time she has been the associate director of nursing in charge of education at her home school.

Nurses are particularly fortunate in being able to combine a love for travel with the practice of their profession. Miss Christie's career in the years 1949-53 provide substantial proof of this. Two years were spent in New Zealand in various hospitals in a supervisory capacity. Australia, being comparatively close at hand, was the next stopping point for five month's experience as a ward sister. Several months as a staff-nurse tutor in Johannesburg provided an opportunity to see some of the beauties of South Africa, and finally a year in England at the Middlesex Hospital, London rounded out a particularly happy period of her personal and professional life.

As a staff member of a provincial association, she comes prepared with extensive knowledge of the responsibilities at this level. The Association of Nurses of the Province of Quebec has benefited from her assistance in various capacities: as a member of the board of examiners; as honorary secretary (one year) and member of the Committee of Management; as chairman of the curriculum committee; as secretary for district XI (English) — four years. Her associates and friends in Quebec will bid her farewell with understandable reluctance but their heartfelt good wishes go with her as she undertakes her new responsibilities.

In July, a Nova Scotian graduate of the Montreal General Hospital became the new associate director of nursing in charge of education of her home school. **Florence MacKenzie,** M.G.H. '47, has served her hospital in a variety of capacities of increasing responsibility since 1952 with a two-year interruption for study at McGill University, where she obtained her bachelor of nursing.

Miss MacKenzie's experience has included nursing service at assistant and head nurse levels, and nursing education as a clinical instructor, clinical coordinator and, most recently, as assistant director of nursing (education). She spent a year as a staff nurse at Camp Hill Hospital, Halifax and a similar period of time as a head nurse on the staff of Welland General Hospital, Ont. At the provincial level, Miss MacKenzie has been chairman of the instructor's group, ANPQ, a member of the Association's committee on nursing education, and on curriculum study.

Early this summer, **Margaret Elder Hart,** the director of nursing education at the University of Manitoba, joined the select company of Canadian nurses who have a doctorate of education. Miss Hart received her degree from Teachers College, Columbia University. Her thesis dealt with the needs

and resources for graduate education in nursing in Canada.

A Winnipeg General Hospital graduate, Miss Hart joined a visiting nurse organization in New York City shortly after obtaining her B.Sc. from Columbia University. Eventually she returned to Canada as educational supervisor in public health nursing for the Manitoba department of health and public welfare. Then, after obtaining her M.A. at Columbia University she accepted her present university position.

Canadian nurses can share a just sense of pride in the accomplishment of this distinguished member of their profession.

(The William Kensit Studio, Edmonton)

JEANIE CLARK

Jeanie S. Clark has assumed her duties as director of nursing of the new Foothills Provincial General Hospital in Calgary. This institution has been planned to provide accommodation for 700 patients and Miss Clark's administrative abilities will be put to good use in the organization of its services. Since 1954 she had served the University of Alberta Hospital as director of nursing and for two years prior to that she was the educational supervisor.

A graduate of University Hospital, Miss Clark obtained her bachelor of science in nursing from U. of A. and worked in public health for a time before continuing postgraduate study at Johns Hopkins University. There, as the recipient of a Rockefeller Fellowship, she completed requirements for a Master's degree in public health. She returned to Alberta and, shortly thereafter, became director of the public health nursing branch in the Provincial Department of Health, a position which she filled most capably for the next few years. This was followed by further study in midwifery in Scotland. In 1952 Miss Clark received her C.M.B. and returned to Canada and University Hospital as educational supervisor.

She has given much already in the practice of her profession and she has much to contribute in the future.

When **M. Geneva Purcell** began her duties as the new director of nursing, University of Alberta Hospital, Edmonton, earlier this month, she had returned home, in a sense, since this western capital was her birthplace. However, her ties with Ontario and Quebec are long-standing. Much of her earlier education plus her professional preparation were obtained in these provinces. Graduation from high school in Ontario was eventually followed by nurse's training at the Royal Victoria Hospital, Montreal. Several years' experience as a general duty nurse, assistant head nurse, and as assistant supervisor, Ross Memorial Pavilion R.V.H. was succeeded by a year of study at McGill School for Graduate Nurses. One year as a head nurse preceded her acceptance of the position of director of nursing, Brockville General Hospital, Ont.

In 1949 Miss Purcell returned to the

(Nakash, Montréal)

GENEVA PURCELL

Royal Victoria as clinical supervisor and instructor in surgical nursing where she remained for the next three years. In 1952 she returned to McGill University to complete requirements for her bachelor of nursing, with a major in administration in schools of nursing. From 1953-55 Miss Purcell was administrative assistant to the director of nursing R.V.H., leaving this position to become the supervisor of the Royal Victoria Montreal Maternity Hospital. Recently she rounded out her postgraduate study by obtaining her Master of Science in Nursing from Boston University, Boston.

In spite of a busy schedule of work and study, Miss Purcell has always found time to take an active part in professional activities at different levels. She is a past chairman of the ANPQ Committee on nursing service, of the CNA Task Committee on nursing service and of District XI (English division) ANPQ; former second vice-president and honorary treasurer, ANPQ. She has served both her school of nursing alumnae association and that of the McGill School for Graduate Nurses as president.

A variety of hobbies occupy off-duty hours. Miss Purcell enjoys golf and photography; her friends can vouch for her skill in cooking, knitting, sewing and for her talents as a hostess. She is a member of Beta Sigma Phi exemplar chapter and of Sigma Theta Tau, an American nurses' national honor society. Finally, this account would not be complete without mention of one other interest. She owns (or, perhaps we should say, is owned by) an intelligent, if somewhat demanding, Siamese cat.

A very capable nurse administrator, Miss Purcell will approach her new duties with the same efficiency that has been characteristic of her professional career to date.

In Memoriam

Gladys Mary (Smith) Barnet (Misericordia Hospital, Winnipeg '30) died in Winnipeg.

* * *

James Bolton (Clayton Hospital, Wakefield, Yorkshire) died in Winnipeg on May 23, 1962. He was operating room supervisor at the Winnipeg General Hospital at the time of his death.

* * *

The Alumnae Association of the Montreal General Hospital pays tribute to the memory of: **Lily Carpenter** '26; **Julia (Andrews) Milligan** '40; **Margaret Ruth (Robertson) Shaver** '16.

* * *

The Alumnae Association of St. Michael's Hospital, Toronto pays tribute to the memory of: **Pearl M. Coffey** '26; **Katherine (Lavis) Lebeau** '26.

* * *

Emily Jean Ellis (Vernon Jubilee Hospital, B.C. '28) died in Vancouver on May 2, 1962.

* * *

The Alumnae Association of the Children's Hospital, Winnipeg pays tribute to the memory of: **Annie (Coppleman) Good** '23; **Minnie Kelly** '14.

* * *

Gertrude Elinor Halpenny (Lady Stanley Institute, Ottawa '08) died on April 13, 1962. Miss Halpenny enlisted in the armed services as a nursing sister at the outbreak of World War I and served in England, France and Greece. She was awarded the Royal Red Cross and the Mons Star in recognition of her contribution.

* * *

Ethel (Johnson) Hanna (Brandon General Hospital, Manitoba '26) died on April 10, 1962.

* * *

Madge (Sloan) McAllister (Owen Sound General and Marine Hospital, Ont. '38) died in Scotland on April 20, 1962.

* * *

A memorial tribute is paid to the following deceased members by the Alumnae Association of the Winnipeg General Hospital: **Mary Evelyn (McLean) McCallum** '37; **Mabel May Skinner** '21.

* * *

Ella Masterson (Toronto Western Hospital, Ont. '12) died on March 27, 1962 in Highland Park, Michigan.

* * *

Jessie Matheson, a native of Prince Edward Island, who practised her profession in the United States, died on May 22, 1962 in Brockton, Mass. She had served the God-

(Continued on page 703)

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

VON Annual Meeting

HER MAJESTY QUEEN ELIZABETH THE QUEEN MOTHER attended the 64th annual meeting of the Victorian Order of Nurses and was welcomed as Grand President of the Order. This was the first time that the honorary head had attended a meeting, although Her Majesty is the fourth Queen to extend her patronage and interest.

Queen Victoria's name was given to the Order when it was founded in 1897 on the occasion of the Diamond Jubilee. In 1901 Queen Alexandra became the first Patroness and remained so until her death. Queen Mary was Patroness from 1911 to 1953. In 1955 the royal tradition was renewed when Queen Elizabeth, the Queen Mother, graciously allowed her name to be placed at the head of the Order as Grand President.

Over 300 members attended the annual meeting held in the Chateau Laurier Hotel, Ottawa in June. Miss HELEN CARPENTER, immediate past president of the Canadian Nurses' Association addressed the luncheon meeting on the first day. HIS EXCELLENCY THE GOVERNOR GENERAL and MME VANIER invited the Board of Governors and the members to hold their closing meeting at Government House. His Excellency is patron of the VON and Her Excellency is honorary president. Capt. JOSEPH JEFFREY, O.B.E., Q.C. of London, Ontario, presided at this meeting at which Miss JEAN LEASK, director in chief, gave her annual report. Following brief remarks by Her Majesty, tea was served.

News from ICN

Completed ICN questionnaires on the family's part in caring for the patient were received from 21 national nurses' association including Canada. The draft analysis of these questionnaires will be presented to the ICN Nursing Service Committee at its meeting in August. Miss ALICE GIRARD, dean, Faculty of Nursing, University of Montreal, is chairman of this committee.

Study Awards

The Awards Committee of the Canadian Nurses' Association met in National Office in June to study applications for fellowships. Forty-one applications for the W. B. Saunders' Nursing Fellowship were considered. It was awarded to Miss MARGARET STEED, Kitchener, Ontario.

Two applications for the British Commonwealth Nurses' War Memorial Fund Scholarship were considered. This Scholarship was awarded to Miss MARY N. TURNER, Toronto.

Nursing Service

The Advisory Committee to the Special Project for the Evaluation of Quality of Nursing Service met to develop criteria at a three-day workshop. The meeting was held at the Laurentide Inn, Ste-Agathe des Monts, P.Q.

50th Anniversary

Miss F. LILLIAN CAMPION presented pins and diplomas to the 1962 graduating class of The Wellesley School of Nursing, The Wellesley Hospital, Toronto. The hospital is celebrating its 50th Anniversary this year. Miss Campion is an alumnus of its School and Director, Project for the Evalu-

ation of Quality of Nursing Service.

Public Relations Programs

Many hospitals are distributing booklets or brochures to patients on or before admission to hospital. The booklets give concise, accurate information concerning hospital accommodation and services. This type of publication serves to acquaint the patient with hospital procedures and to welcome him. It also helps to assure the patient that the hospital staff recognize that he is in a strange environment and that his questions will be appreciated and answered. Some hospitals show added courtesy to patients by publishing these booklets in several languages. National Office would welcome a copy of your booklet.

LETTER FROM SPAIN

SUZANNE GIROUX

The nurse's interest in human nature simply increases with the years and travel provides an opportunity for its expression. A holiday in Spain earlier this year was highlighted by a visit to a school of nursing in Majorca.

Palma, the capital of the Island of Majorca, has a population of 150,000 which is considerably increased in summer by tourists. The latter are attracted by a climate described as perpetual springtime. The city rises from the seashore up the slopes of the hills encircling the bay.

The hospital is beautifully located on the outskirts of the city at the summit of a hill, in the midst of a pine woods and with a view of the sea in the distance. The cream stucco building has seven floors and a basement. The school of nursing occupies the top floor. This institution is for the use of those participating in the hospital insurance plan of the State. In addition Palma has numerous private clinics and a hospital for the poor.

I chatted with the hotelkeeper about the hospital insurance program. It is obligatory for all salaried employees and more recently for agricultural workers.

The first floor of the hospital houses the administrative offices, X-ray, laboratories and the emergency department. The kitchens and the laundry are in the basement. One floor is set aside as an obstetrical department and there is a pediatric unit. The remainder of the hospital's wards are devoted almost completely to surgery. The operating suite is comprised of six theatres, anesthetic and recovery rooms. There is also a central supply department.

There are 45 beds on each floor divided into three-bed units. Each unit has its own complete bathroom. There is a little dining-room for ambulant patients on each floor with its own kitchenette where food from the main kitchen is kept hot until needed. There is also a small dispensary and a linen-room.

In the pediatric unit, an adult bed is set up beside each child's cot. The Spanish mother comes into hospital with her child and looks after him. Her baby is with her continually, sick or well. She goes shopping with him in her arms; he comes with her as she chaperones her older children to school each day. To suggest separation during illness would be impossible.

The presence of relatives in the recovery room was a surprise. The doctor accompanying me admitted that this, perhaps, was not as it should be but that if anything happened to the patient without some member of the family present, there would be no forgiveness! The Spanish family is closely knit; its members share good and bad fortune alike.

The nursing personnel was composed of 10-15 graduate nurses assisted by students and nursing aides. Each category had a distinctive uniform. Members of religious orders formed part of both the graduate and student nurse groups. There were 150 patients in hospital on the day of my visit — none seriously ill or badly injured. Patients requiring neurosurgery or thoracic surgery are referred to institutions in Barcelona. Offhand I would estimate that the hours of nursing care per patient are below that of the hospitals in our large centres. However, considering the more moderate pace of activity; the average length of hospital-

ization, 15-20 days; the role played by the family and the general standard of living, everyone — doctors, patients and families — seemed satisfied with the care provided.

The hospital is under the direction of an administrator and a doctor. There is no director of nursing. A lay nurse or a member of a nursing sisterhood was in charge of each floor. The building was extremely clean and everything seemed to function most efficiently — except the elevator!

The school of nursing had only been in existence for two years. Three schools were founded in Majorca about the same time. At this particular school, three lay nurses — the director of the school, the director of nursing education; and an assistant — formed the teaching personnel. There were 18 students. The school's physical facilities were quite good, with adequate provision for class rooms, study rooms and demonstration rooms. The library, unfortunately, had very few books. There was no science laboratory. The furnishings throughout were attractive.

The educational director showed me a graph of the year's examination results. They were low in pathology and science. All courses were given by doctors. When I inquired from the doctor with me if this was considered to be a good arrangement, the nurses gave him a hard look and he contented himself by saying that an instructor reviewed each course with the students and, as far as he was concerned, practice was the main thing. I agreed that practice was important but I pointed out that it should be based on fundamental principles.

The educational requirement for admission to the school of nursing was a school-leaving certificate equivalent to our Grade XI.

The tour ended with a visit to the chapel, the conference room, the huge air-conditioned amphitheatre and the doctor's assembly room where two portraits were prominently displayed — Franco and Jose Antonio Riviera, a military leader killed very shortly before the outbreak of Spain's civil war. Riviera was a fine-looking man and a personal hero of my young doctor companion. He was pleased with my suggestion that Riviera was a modern "El Cid."

I was interested in the number of blind people in Spain. I was told that this was largely due to the low cultural level in Southern Spain. When I pressed for a more specific cause, the doctor told me that trachoma was the main factor because the people were ignorant and did not know how to look after themselves. An intensive educational campaign had been carried out as a means of improving the situation.

The hospital's chief radiologist discussed hospital insurance with me. He called it the "grave-yard of the doctors." His younger colleague could not understand why the system had been changed. He felt that the people had been well-cared for previously and that they had paid relatively little for the service. However, both men agreed that a problem did exist in the provision of care for those with moderate incomes, children to educate, elderly members of the family to support. These were the people who tended to postpone medical care for themselves and the large numbers of the blind were proof.

Thus ended a delightful and most interesting visit.

(Continued from page 700)

dard Memorial Hospital, Brockton for 49 years and for 20 years as director of nurses.

* * *

Maud Mirfield (Royal Jubilee Hospital, Victoria '21) died in Vancouver on April 29, 1962.

* * *

Lourine (Grant) O'Neill (Public General Hospital, Chatham, Ont. '46) was instantly killed in a car accident on April 15, 1962. Mrs. O'Neill was head nurse of the Intensive Care Unit, St. Joseph's Hospital, Chatham at the time of her death.

Marion Winnifred Oliver (St. Boniface Hospital, Manitoba '19) died on April 12, 1962.

* * *

Sister Marcel Joseph (Juliette Boyer, Hôpital du Sacré-Cœur, Hull '33) died on April 30, 1962. She was formerly on the staff of Hotel Dieu de l'Assomption, Moncton, N.B. and latterly had served at Hôpital général du Christ-Roi, Verdun, P.Q.

* * *

Anita Marguerite Woodcock (Chipman Memorial Hospital, St. Stephen, N.B. '39) died in St. Stephen on April 23, 1962.

LONG-TERM HOSPITALIZATION

MARGARET MACKENZIE

With the growing realization of the psychological implications involved in the separation of the young child from his mother, there appears to be a real need for revision of our attitude towards hospitalization, and hospital care for children.

THE FUNCTION of a hospital is to treat and cure disease and disability. Is the hospital really fulfilling this function if, in curing the physical condition, it jeopardizes the child's future by creating emotional disturbances? Emotional disturbance can be just as painful and costly as physical ill health.

Does the age of the child have any effect on the degree of disturbance? Bowlby notes that there are three stages in the mother-child relationship. Separation in any one may interfere with the child's ability to relate to people in later life. The first phase, from birth to one year or less, is the period when the child learns to relate to one individual. If he is not able to accomplish this early relationship, he will have great difficulty with later ones. The second phase continues on to three years of age and over. During this period the child needs his mother constantly in order to build upon the relationship already established. According to Robertson children under four fall into this group, since findings indicate that they appear more adversely affected by hospitalization. This may be due, in part, to the traumatic experience, coupled with separation before the child can cope effectively with the latter.

The third stage is from about three to five years of age. The child is able to sustain relationships with the mother during short periods of separation. In other words the older child is more able to cope with separation. The infant, however, is adversely affected, because he never learns to build a relationship. The ability of the child to talk, and to understand verbal explanations increases with age, though the understanding of a four-year-old is questionable. It is important to recognize that inherited capacities, physiological maturation and environmental influences all play a part in the emotional development of the individual. The response of each child to a particular experience will be different.

Reaction to Separation

Robertson describes the three stages of "settling in." The first phase is *protest,* in which the child may cry, throw himself around the crib, follow every sound in the hope of finding his mother. The second is *despair.* The child wants his mother; may cry quietly; becomes withdrawn and apathetic; usually protests when the mother leaves after a visit. Even after very short periods of separation, the child may reach this stage.

The last stage, *denial,* follows gradually on the second. The child shows increased interest in his surroundings and in toys. He lacks interest in his mother's visit, and may not fuss when she leaves. He cannot understand the separation, and represses his feelings for his mother who appears to have failed him. He has no other means of dealing with his feelings. This stage is reached by children hospitalized for long periods of time.

Long-term hospitalization for children may be for medical reasons; for correction of congenital abnormalities involving surgery; for accidents, particularly burns and poisoning; for certain communicable diseases such as tuberculosis and poliomyelitis.

Elective surgery frequently requires a shorter period of hospitalization. It is the surgeon who decides when it should be done. Studies indicate that even short periods of separation, two to eight days, may create emotional disturbances for varying lengths of time in children under four. These disturbances have persisted up to six months after discharge and even be-

yond. These children could scarcely have reached the denial stage, yet they had been injured sufficiently to experience emotional difficulty for long periods of time. What would have been the effect if they had been hospitalized for several weeks or longer? It gives both public health and hospital nurses much to think about.

The Nurse's Responsibility

There are four areas in which the public health nurse can make a far greater contribution than she has done to date.

The first is education in accident prevention. This should be started as soon as possible after the first contact with the mother. Such things as pan handles sticking out over the edge of the stove; teapots left within reach of the child; leadfree paint on cribs and toys; safe storage of drugs and poisons, all of these are factors in child safety. Some should be discussed before money is spent; others will require practice in order to change existing habits. Subsequent safety teaching should be based on the developmental process of the child. Parents should realize that what the child cannot do today, he may be able to do tomorrow, and they should be prepared.

The second area is the mental health aspects of child care, including preparation for hospitalization and the child's need for the presence of his mother. The usual reply to questions about hospitalization is of the "reassurance" variety: "They settle in a day or so;" "they make friends with the others;" "the nurses love the little ones." Where there is a known need for hospitalization, the mother must have far more preparation. If a nurse has difficulty in communicating to the mother that procedures may hurt, or be unpleasant or unconfortable, how much more difficult it is for the mother to communicate this to the child. If the mother is to understand the importance of telling the truth to the child, she will require help in appreciating the many implications of *not* doing so; guidance in what to say; assistance in making arrangements for the other children if she is permitted to remain or to spend long periods with the child in hospital.

The third area has to do with the public health nurse's attitude towards early discharge; giving demonstrations regarding care of the child; assisting the mother in planning to meet the new demands. The policies of the agency and the hospital come into the picture. Routine can be such a safe and pleasant escape from problems! If adults can be discharged with colostomies or on insulin and other drug therapy, is it not possible to teach mothers to care for their children, or to have visiting nurse services? How much use is made of the visiting nurse in the care of children?

The prevention of infection is also the public health nurse's concern. The nurse's understanding of herself as a health teacher is basic to success here. Too often we blame "conditions" in the home or the incompetence of the mother rather than our own inability to teach, or to find motivating factors that will bring about the desired result.

If the public health nurse could do a more effective job generally, her counterparts in the hospitals might be able to change their views.

Long-term Hospitalization

Hospitalization will continue to be necessary for some children. Long-term care poses a rather different problem than the short-term situation, where, if the mother is permitted, she may stay with the child and, if necessary, take a younger child with her or have the other children cared for at home. Where long hospitalization is necessary this does not appear to be too realistic an approach.

The mother might be allowed to stay until the child becomes accustomed to his new surroundings and to those who will care for him during her absence. Visiting should be unlimited, so that the mother may spend as much time as possible with the child. The mother might gradually lengthen the period between visits, particularly if the child is able to be out of bed. The child needs to have some of his own pet toys and his blanket, or whatever it is he requires to go to sleep.

The Ward Staff

The question of staffing children's

wards is important. Robertson points out that a succession of nurses with whom the child learns to make some contact and who then leave him, only strengthens his feeling of being deserted. Permanent staff should be considered. This excludes the use of student nurses on these wards. If the preschool child has difficulty in relating to large numbers of people, it appears obvious that small units would be helpful, apart from the fact that they could be made to look more homelike.

Permanent staff could be assigned to the small unit, and each member would be responsible for the personal care of certain children — a basic factor in developing relationships. The children would come to know the other staff members so that when "their nurse" was off, they would not have to adjust to care from strangers. Staff hours might even be arranged so that each child had his particular nurse with him for all meal hours.

Mothers should be encouraged to visit as much as possible, and to stay overnight on occasions. Should there be need for further surgery or extensive treatment, the mother should be included in the planning and arrangements made for her to stay for a few days if possible. However, all "extra" visits by the mother should not be only when the child has to face a traumatic experience.

There is a need to determine how such plans and arrangements can be effected. A higher staff/patient ratio will probably be required. Administrative problems will increase as a result of rearrangement in working hours; mothers coming and going; a decrease in routines and orderliness.

Where the mother is present and assisting in the care of her child, nurses may appear less busy than they should be. It is possible that uniforms could be discarded in favor of washable dresses of a uniform style with a distinguishing badge.

Finally, the nurse needs a far better understanding of children. She must be able to tolerate the child's crying for his mother when she leaves; his hostility towards her as a substitute. She must watch for signs of despair, and recognize it for the danger it is; accept the fact that though the child demands much of her in his mother's absence, he is not her child. She must learn to work with the mother and help both her and the child to maintain as close a relationship as possible. The nurse's satisfaction should come from restoring a child to his family physically cured, and emotionally as undisturbed as possible.

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Excellence in Nursing — Progress in Health

The American Nurses' Association held its biennial convention in Detroit from May 14-18. The interest shown in the Association's activities may be measured by an attendance of 8,446.

THE ANA MEMBERSHIP of 170,911 is divided into eight sections organized according to area of practice. These are: Counselors, executive secretaries and registrars; educational administrators, consultants and teachers; general duty nurses; nursing service administrators; occupational health nurses; office nurses; private duty nurses; public health nurses. The program for this convention was divided into business and program meetings of the eight sections, business meetings of the House of Delegates, general program meetings and, an innovation for the ANA, 21 clinical sessions.

Clinical Sessions

The convention theme "Excellence in Nursing—Progress in Health" was given tangible expression in the scheduling of clinical sessions which occupied the equivalent of one full day of the convention. A total of 74 papers, focusing on the ways the professional nurse can use research, technical innovations and advanced scientific knowledge to improve her skills in comprehensive patient care, were presented. So that registrants could attend more than one session all the papers were given on two days. Judging by the attendance at these sessions, the discussions that followed them, and the reaction of the registrants, many nurses would liked to have been able to attend more than two. The ANA is making monographs of the papers available to those who are interested at a minimal cost of reproducing them. They will be available in September; an order list appears on page 709.

Another innovation of the 1962 Convention was the presence of a cabinet officer as a key speaker. The opening program meeting was addressed by Abraham Ribicoff, Secretary of Health, Education and Welfare, who appealed to nurses to use the knowledge we have gained in "the unfinished business of health."

> The health record of this country is a random harvest of mixed blessings. We have eliminated the fear of the great plagues of the past, yet many thousands of us still suffer unnecessarily from infectious diseases we know how to prevent.
>
> Our infant death rate is low, but in nine other nations of the world it is lower still. We exalt the human mind, yet our treatment of the mentally ill is just beginning to emerge from the Dark Ages. Our life expectancy has jumped 20 years in two generations, yet many have been spared an early death only to reach an old age in which prolonged illness robs them of pride and purpose in living.
>
> If the flow of miracles from the laboratories were to stop tomorrow, we could still transform the nation by applying universally the knowledge we now possess . . . The flow of miracles will not cease, but the delivery of services must increase and accelerate . . . The sad fact is that there are men, women and children across this land who cannot get the right health services at the right time and in the right place. And if they cannot get these services — for reasons of finances or unavailability — then all our hard-won findings are hollow and meaningless . . . Every preventable death accuses us.
>
> . . . Obviously the nurse is a key, a vital, member of the health alliance. But we do not have enough nurses — in any field or at any level. Those that we do have do not have enough educational opportunities . . . It's always nice to be in demand . . . it is a tribute to you . . . but the demand for your services is increasing. The theme of the majority of new health proposals is "home care," but in 1960 a study showed that 30 per cent of the incorporated cities with populations of 25,000 and over did not have any home nursing

care services. Everyone wants and needs nurses, here and abroad.

What do we need to do? How can we work together to strengthen your professional and our larger, national cause?

First, we need to move ahead in nursing research. Which nursing practices need to be improved? How can the professional nurse better use her time? Which of her duties can be delegated to others? Above all, how can she do everything she must do and still retain her warmth — her all-important ability to care?

Next, we must plan our services so that they really meet the needs of people — of human beings you and I know. Let's take a look at the administration and organization of nursing services. Do patients — even doctors — know what services are even available in each community? Are these services being delivered as fast as they can be?

Couldn't we make more use of the nurses who are trained and experienced but who are not working? Rigid rules and artificial requirements must not cause us to ignore this important trained group.

We must attract and educate new nurses. We are all agreed that we are not doing a proper job of this now. We do not have adequate education programs, either in quantity or quality, to prepare nurses in preventive medicine, to serve in public health, schools, industry, and the clinical specialties such as psychiatric nursing.

We are pitifully short of qualified nurse educators. Only about seven per cent of the professional nurses in our country have a bachelor's degree, and only roughly two per cent a master's degree. Unless we improve educational opportunities for nurses, we simply will not have the personnel to nurse — to teach — or to supervise the increasing number of people who must perform the less-skilled nursing tasks.

In closing, Secretary Ribicoff mentioned a study which is underway to determine the nation's needs in the field of nursing and to recommend an action program. Nurse members of the group of consultants to the Surgeon General include Judith Whitaker, Executive Secretary of the ANA, and Dr. Eleanor Lambertsen, Chairman of the Department of Nursing Education, Teachers College, Columbia University. The speaker expressed the expectation that "the report will be a monumental contribution to our understanding of the role of nursing in our society and that it will plot a course for orderly improvement of nursing service and nursing education."

General program meetings included an interesting and lively panel discussion entitled "Focus on the Future — Economic Security in the Decade Ahead." Emphasis was placed on the need to raise economic standards of nursing as the key to recruitment by Mrs. Esther Peterson, Assistant Secretary of Labor. Congressman James O'Hara told the meeting that the necessary first steps in their economic security program are the legal protections that most other occupational and professional groups have enjoyed for more than 20 years. Mrs. Anne Zimmerman, Executive Secretary of the Illinois Nurses' Association, agreed with Mrs. Peterson that "a strong relationship exists between education and economic status, excellence in nursing service, excellence in nursing education and excellence in nursing economics are so logically intertwined as to be inseparable." Mrs. Zimmerman encouraged nurses to seek support from the community. "Community support won't manifest itself unless the nurses themselves stimulate it."

Interest in nursing research was evidenced by the number of registrants who attended the Conference Group on Research. Although this meeting, entitled "Defensible Criteria and Tools for Assessing the Quality of Nursing Care," was listed in the program as a technical discussion for researchers, many more rows of seats were added to a large room to accommodate interested nurses and many registrants had to be turned away.

Integration of minority groups into professional nursing associations has long been a subject of activity of the ANA. It is to the credit of the Association that the last state nurses' association to admit qualified nurses to membership regardless of race, color or creed, did so during the past biennium.

The House of Delegates had several busy sessions during the week. One of the liveliest involved the motion to change the bylaw regarding ANA fees. In a roll call vote by state, the delegates approved a dues increase of $5.00. Annual dues for a member of the ANA will now be $12.50. This is over and above the membership fee in each state nurses' association.

It is not feasible to give complete coverage in our *Journal* to a convention of this magnitude. Those interested in a more detailed report of meetings and addresses should refer to coming issues of the *American Journal of Nursing*.

PAMELA E. POOLE

1962 Convention
American Nurses' Association

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BULBAR POLIOMYELITIS

STEPHANIE SEMKO

Poliomyelitis is a much-dreaded viral infection. The bulbar type is the most serious form in which it occurs.

The Patient as a Person

ADMITTED to hospital with an uncertain diagnosis — possible meningitis, cerebral vascular accident, or poliomyelitis — Mrs. James' final diagnosis was bulbar poliomyelitis.

She was a very pleasant 27-year-old, of average intelligence. She had been married for over seven years and was exceptionally proud of her family of three — two boys and one girl. Her husband appeared very devoted. His frequent visits, bringing up-to-date news of the children and home affairs, helped her a great deal to stay emotionally at ease. Mrs. James appeared to be well nourished, clean, dressed in fairly modern clothes. She took a real interest in her personal appearance. Of an even temperament, usually cheerful and cooperative, she conversed quite easily on many subjects, although she enjoyed talking of her family best. She was an only child, but hopes to have a large family of her own. She was employed as a travel consultant before her marriage and liked her job very much.

She attended Sunday School as a child, church with her parents, and now with her family attended church quite regularly. While in the hospital the minister of her church visited her frequently. This she enjoyed and appreciated.

Mrs. James adjusted easily to the hospital ward. She enjoyed company and was somewhat distressed when isolation technique was established. However, with explanation, she understood the reason and cooperated very well.

The Disease

Poliomyelitis is an acute communicable disease caused by a virus which is resistant to present types of antibiotics. There are known to be three different types of virus causing poliomyelitis thus an individual can have more than one attack.

The virus enters the body through the nose and mouth and in all probability reaches the gastrointestinal tract where it grows and multiplies.It then passes through the tissues into the blood stream where it causes "virusemia" and consequently a fever develops. Following this the central nervous system may be affected and nerve cells may be damaged or destroyed.

As the motor cells in the brain and spinal cord are attacked, muscle weakness and paralysis become apparent. The muscle fibres are not damaged by the virus, but the destruction of the nerve cells makes them useless. Only a few muscle fibres or the whole muscle may be affected, depending on the extent of nerve involvement.

The body develops antibodies which help to destroys the virus. These may be sufficient to overcome the virus at any stage of the illness. Thus the condition is self-limiting since the defence mechanisms overcome the disease process but patients may be left with varying amounts of paralysis.

The degree of recovery will depend on the extend to which nerve cells are damaged or destroyed. This cannot be determined during the acute stage. If the nerve cells are not destroyed, they will regenerate and the nerve fibres reaching the muscle will gradually resume function. It is highly important that the muscle bulk be protected until the nerve fibres have recovered.

Poliomyelitis is differentiated according to the areas of the central nervous system affected:

1. *Lower spinal* — the lower trunk and extremities and the urinary bladder;
2. *Upper spinal* — upper trunk and extremities including muscles of respiration;
3. *Bulbar* — the muscles of the face, eyes, larynx and pharynx.

In any one of these types there are three stages: acute, convalescent and chronic. In each stage, a positive at-

titude should be taken by those coming in contact with the patient emphasizing what he can rather than what he cannot do.

Acute stage

The symptoms may be very mild and considered relatively unimportant, or they may be very marked. They include: fever, general malaise, sore throat and anorexia. Nausea and vomiting may be present also. This is the systemic phase. It may last for one or two days and then the patient appears well for the next seven days. When he becomes ill again meningitic symptoms may develop which indicate involvement of the central nervous system. The muscles become sore and stiff; the patient becomes apprehensive and irritable. Muscular weakness or paralysis with muscle spasm and rigidity develops in this paralytic stage.

Isolation

Isolation technique should be carried out for the first seven to fourteen days. It should include all of those concerned with the patient: doctors, nurses, family, administration, and housekeeping staff. It is necessary that there be full understanding and follow-through by all of those concerned.

Convalescent stage

This stage begins when the temperature drops to normal. It is during this phase that the muscles will recover their function and their reeducation should begin. The patient may be permitted to return home.

Incidence and Prevention

Some authorities state that 80 per cent of the population of this country have had poliomyelitis at some time which was not recognized and which left no residual paralysis. Only the complicated and exceptional forms of poliomyelitis are reported. It is estimated that probably one person in one hundred becomes paralyzed.

The large scale trials conducted during the spring of 1954 with the vaccine developed by Salk, demonstrated the feasability of "active immunization." The fundamental purpose of administrating vaccine is *to prevent paralysis*, not to prevent infection! The vaccine is of no use in the treatment of poliomyelitis. Current estimates of efficiency of the Salk type vaccine, as documented in the past six years, show that a marked reduction in the number of cases of paralytic poliomyelitis has taken place. Its continued and wider use should not only be encouraged but urged, since it is the only official prophylactic agent against poliomyelitis.

Live polio vaccines should be regarded as products which are still in the experimental stage although the present results of field trials — some of which have been very extensive — have been very promising.

The First Attack

Mrs. James had had polio in 1950 when she was 17 years old. She was hospitalized for the first six days of her illness only. Her symptoms consisted of a general tightness of her arms and legs, headache and general malaise. She received no specific treatment while in hospital but was placed on very strict bed rest. Upon returning home, "hot pack" treatments were used on her arms, legs and hips for one month. This was the month of July, and one July she will never forget! Her back pain subsided shortly after her return home. She recovered from this attack quite fully.

The Second Attack

At the onset, Mrs. James recalled that she "just felt completely tired and dragged out." She awoke on the morning of December 31, 1960 with a slight headache. By evening she felt generally miserable. In the following days she became nauseated and vomited nearly all the food she consumed. Her headache, by now, was very severe. She described it as follows: "It felt just as if there was a big lump at the base of my head pressing against my brain."

She did not feel "dizzy" but her equilibrium was upset. Then her neck muscles became limp and she could not lift her head up off the pillow. The left side of her neck appeared normal but the right side was very weak. There was a stabbing pain in her hips, but she did not notice this so much in contrast to the severe headache and back pain. She realized that her speech was becoming quite muffled but this, she thought, was the result of a bad case of sinusitis.

Her doctor visited her on the third

day of her illness and gave her three kinds of medication which, she said, were sleeping pills, pain pills and antibiotic. Her headache was relieved, but now the pain in her hips became more pronounced — especially when she was lying down. She continued to be nauseated and now she noticed mucus collecting in her throat. However, she felt better and attempted to get up and around the house but with some difficulty. Her left leg felt weak and she had to walk stiff-legged because if she bent her knees she collapsed. Finally she returned to bed to stay.

Mrs. James recalls that at this time she had some difficulty when eating because of nasal regurgitation and a slight weakness on the right side of her face. Her throat was not sore; she could manage liquids but solid foods stuck in her throat.

A few days later she noticed that her right eye was not blinking. Her speech was becoming more slurred, and her facial paralysis became noticeably worse. Twelve days after the onset she was admitted to hospital.

Admission notes included the following remarks;

> She and her husband had never received Salk vaccine but their children were in the process of obtaining injections. She had soreness in her left arm, hip and leg; difficulty in movement; no muscle movements of the right side of her face; severe headache present then and for three days prior to admission; nausea and vomiting which had been troublesome for the past week; difficulty in swallowing; a marked slurring of speech. She was unable to raise her head off her pillow. Her blood pressure was within normal limits; temperature slightly elevated, 99-72-20.

She was placed on complete bed rest and given an analgesic for pain.

Laboratory investigation

> Hematology studies revealed an increase in neutrophils to 84% (normal 40-70%) which is indicative of infection. Urinalysis showed normal results. The cerebrospinal fluid showed an increased number of white blood cells, 29/cu.mm. (normal 0-7/cu.mm.), again a possible indicator of infection; a much increased protein content, 276 mg. % (normal 10-45 mg.%) which pointed to degenerative disease; and an increasing sugar content, 57 mg. % (normal 45-75 mg. %) which is indicative of a viral infection.

Neurological Examination

> Tests in connection with this procedure revealed that Mrs. James spoke with obvious paralysis of the palate; had a peripheral type of right facial weakness of plus three magnitude; showed good pupillary reaction although her right eyelid did not blink; had a suggestion of weakness in her left arm with a definite weakness of her left leg of plus two magnitude.
>
> Sensory tests showed entirely normal results. The diagnostic impression was poliomyelitis.

Physical examination

> Mrs. James showed gross weakness of the right side of her face, weakness in both sternocleidomastoids, the biceps, triceps and deltoid muscles of the left arm; sore calf and thigh muscles on the left side; weakness of the right iliopatal, left iliopsoas, glutei maximi and calf muscles.
>
> No muscles were totally paralyzed except those in the right face and these were showing signs of recovery.

Treatment and Nursing Care

There is no specific treatment for poliomyelitis. None of the antimicrobial drugs that have been tried have been found to have any effect in destroying the virus or controlling its spread throughout the body.

It is very important during the febrile period of polio that the patient should be kept quiet, in bed, and under observation. Patients are potentially infectious and should be placed on separate technique. Mrs. James was placed in isolation on admission.

The nasal voice, nasal regurgitation and difficulty in swallowing revealed that she had palatal and pharyngeal muscle paralysis. As this difficulty became more pronounced there was an increase in drooling and spitting. Suction apparatus was constantly at her bedside although it was not used, since Mrs. James was able to expectorate adequately.

Dietary treatment

The dietary orders on admission were for forced fluids only. Help and encouragement were needed for her to

take these fluids, even in small amounts. Careful observations were made in relation to her swallowing reflex. A constant supply of fresh, cold fruit juices and water made the fluid diet more palatable for the patient. Pineapple or apple juice were given in preference to milk which tended to cause formation of mucus.

The diet was gradually increased to full fluids and then to a soft diet as Mrs. James improved. Still she seemed to have anorexia and took her meals only fairly well. She was able to feed herself. It was only after a B-plex preparation was ordered that a definite improvement was noted in her appetite. It continued to improve throughout her convalescent stage to such a degree that she asked for second helpings and snacks at bedtime.

Nursing treatments

Mouth Care: Mrs. James received mouth care and mouth washes every four hours. She found this very refreshing and looked forward to this part of her care. The type, amount and quality of expectorated mucus was noted regularly.

Skin Care: A complete bed bath was given every morning. Since the patient was on complete bed rest it was important that her skin should be kept clean and free from irritation. Clean linen, pulled tight to eliminate unnecessary wrinkles, helped to make her more comfortable. Back care was given frequently during the acute stage to provide a restful change of position as well as protect her skin. As she progressed, however, back care was given every four hours.

Elimination: Mrs. James had difficulty in using a regular bedpan. A slipper bedpan was labelled and used only for her. She voided normally and her bowel movements were regular. While on seperate technique her bedpan was considered contaminated and was thoroughly sterilized after each use.

Eye Care: Mrs. James' right eyelid did not blink due to the paralysis of the right face. An eye irrigation was given every four hours. This cleansed and lubricated the eye. She was encouraged to frequently close her eye manually.

Exercise

The patient was placed on complete bed rest on admission. Her body alignment was carefully noted and maintained. Four days after admission, passive exercises to all extremities, especially the lower ones, and movement of all joints were ordered.

Thus her regime with the physiotherapy department began. The reports from this department noted that she did not have any discomfort or limitation of movement when taking her exercises. These were given every four days. Progressive notes indicated the joint function had improved. However, her speech remained slurred. Galvanic treatments to her face muscles were begun.

Ten days after admission Mrs. James was taken off isolation technique. Her exercise was increased to the extent that she could sit up in the chair twice a day. Some help was required to get her up, but once up, she thoroughly enjoyed these "mobile" periods. She moved into the large ward where she enjoyed the company of the other patients.

One week later she was able to be up in a wheel chair. She particularly enjoyed this and it reflected on her in that she became much brighter and more cheerful. She felt that she was truly progressing.

Continuing her interest in her personal appearance, Mrs. James asked if she could wash her own hair and received the doctor's permission.

Although she had regular treatments for her facial paralysis in the physiotherapy department, she was encouraged to do other simple exercises such as to blow out her cheeks, raise her eyebrows, try to whistle and massage her face muscles. After having these demonstrated by the physiotherapist and the nurse, she did these exercises very well and very faithfully. She was conscious of her facial paralysis but did not let it depress her since she was confident that it could be overcome. Her husband's reassurance helped her to face this situation.

Medications

There is no specific drug that will cure poliomyelitis. However, during Mrs. James' stay in hospital she re-

ceived the following medications:

1. Frosst 292: Acetylsalicylic acid, phenacetin, caffeine citrate, codeine phosphate. These tablets were given approximately q.4h. during the acute phase and later were given only occasionally. They definitely relieved pain and anxiety which are causes of muscle spasm.

2. Secobarbital: This is a short-acting barbiturate producing a sedative effect. It was given orally at bedtime to ensure a good night's sleep. It was very effective and added to the patient's comfort and sense of well-being.

3. Elixir B Plex: A combination of hematopoietic factors in a non-alcoholic orange-flavored base. This preparation was given to improve Mrs. James' appetite and as a vitamin supplement. It definitely improved her appetite, appearance, and general disposition.

4. Magnolax: (Vanilla-flavored emulsion of mineral oil and milk of magnesia). This laxative was given daily.

Psychological Support

One of the most difficult nursing problems related to poliomyelitis is fear. The emotional impact of any illness is an important consideration but it is especially true in this instance. Among the many reasons are:

1. The unpredictable and frequently epidemic nature of the disease;

2. The lack of specific knowledge regarding its spread and immunology;

3. The emphasis placed on the crippling effect and residual deformities;

4. The need for isolation and quarantine;

5. The publicity given to the incidence.

These are some very real fears shared by the patient and her family. To them can be added fear of separation, especially from children; the new experience of admission to hospital and apprehension concerning the course of the disease.

It is very important that the nurse should be calm, efficient and reassuring. She needs to know many of the basic facts about polio in order to do her part in allaying fear and inducing confidence and faith in her patient. It is necessary for the nurse to be able to interpret the patient's behavior in terms of hidden or unexpressed fear. An example of this was when Mrs. James was placed on isolation technique again after one doctor had assumed the febrile period was over. She became very withdrawn and seemed to gaze absently into space. She obviously did not understand why the procedure was being reestablished. However, after an explanation was given and she was reassured that her condition was not worse, Mrs. James regained her natural good spirits.

A calm, friendly, accepting attitude encourages good relationships and helps the patient to discuss her fears and subsequently to face them. It is imperative for the nurse to keep the family well informed about the patient, when they may visit and in what ways they may help. The family relationship meant a great deal to Mrs. James. The high point of each day was the evening visit from her husband. His description of family incidents in detail always inspired her to get well. He was kept well informed about his wife's progress. When isolation technique was established, it was explained to him and he was permitted to talk to his wife for a few minutes each night with due observance of technique.

Principles of Rehabilitation

It must always be remembered that polio is a disease of the primary neurones not of the muscles. The disease is in the substance of the brain and the spinal cord, not in the bulk of the muscle. A principle of rehabilitation must be the preservation of those muscle fibres which have any possibility of reinnervation. The return to normal function is the most fundamental indication of improvement and therefore is the most important consideration in therapy.

All rehabilitation techniques must follow basic principles. Two major ones are apparent:

1. That therapy must increase the total functional capacity of the individual.

2. That therapy will speed up the recovery process, thus avoiding unnecessary convalescence.

An important point, then, is the proper assessment of the individual with poliomyelitis and an attempt to make a sound prognosis as to which muscle fibre will recover and which ones will not. The program must be

developed to fit the specific individual. It must include not only the facilities of the department of physiotherapy but also make allowances for home visits, recreation, intellectual pursuits and re-training.

Follow-up

Six months after Mrs. James was discharged from hospital she was visited at her home. This call was mainly to note her progress and to discuss her treatment and the amount of time spent at the Rehabilitation Centre. She was very pleased to have a visitor from the hospital. She talked freely of her treatments at the Centre where she spent four months, but stressed most of all, how happy she was to be home again. During her first two months she was an in-patient and for the remainder of the time she was an out-patient. Being an in-patient meant that Mrs. James could go home for the week ends. As an out-patient she lived at home and went in to the Centre three times a week.

Here, under supervision, she received treatment to her left leg and arm, and to the right face. This was carried out mechanically as well as through various exercises and swimming. Progress was slow, but her visits home in the first two months were encouraging.

Travelling to and from the Centre as an out-patient did not pose too much of a problem. Mrs. James was able to drive herself. The main problem that she had was to find a trustworthy baby-sitter for the children. With her husand away all day at work, it was necessary for someone reliable to be at home with her three small children. After much searching Mrs. James found a suitable girl, although she still did not rest easy until she, herself, could be home all day, everyday.

Physically, Mrs. James retains a slight limp in her left leg. Her face and her left arm appear normal. She said that her left leg felt much improved, although she still could not put all of her weight on the ball of her foot, and climbing stairs was quite difficult. Her left arm was very close to normal function but there was still slight weakness of the shoulder joint. Her speech was clear again and there was no apparent facial paralysis. Her throat muscles were not quite normal. Mrs. James could not eat very dry foods and if she tried to swallow a rather large bite of food she would have to "wash" it down with liquid.

She was quite resigned to the fact that this was to be the extent of her recovery. She appeared very happy and content in her modern, comfortable home. She mentioned that she was in the process of obtaining her Salk polio vaccine injections, "Better late than never." Her children had had their booster doses of vaccine, and she hoped that her husband would be vaccinated very shortly as well.

Mrs. James will not forget this bout with poliomyelitis. She realizes there is still one more type that she can contract. For some time now she has managed her home affairs very well, but she has found that she must get plenty of rest — at least nine hours a night, or rest periods during the day. However, in general terms, rehabilitation has been very successful.

Stomach cancer cases are so frequent in Iceland that doctors wanted to know why. They found the answer: an unusually heavy diet of smoked meat and fish.

Chemicals in the smoke deposited on the meat, irritated the stomach and over long periods the irritation became chronic and turned to cancer.

Smoked mutton, which Icelanders consider a great delicacy, contained the heaviest dose of harmful irritants, because it was left in smokehouses for weeks at a time, doctors said. *The Financial Post*, Dec. 16, 1961.

Do you recall a speech or conversation that got you riled up? How well did you listen once your blood started to boil?

When someone offers opposing ideas on a matter about which we have a strong opinion, we unconsciously hear something that could make us question our own views. We mentally stop "receiving" him while we plan our verbal counterattack.

The Hearing Eye, Vol. 29, No. 4.

* * *

Public relations — the business of multiplying good impressions.

About Books

Elementary Human Physiology by Terence A. Rogers, Ph.D. 417 pages. John Wiley & Sons, Inc., 440 Park Ave. S., New York 16. 1961. Price $6.50.
Reviewed by Mrs. Freda Woodworth, Royal Jubilee Hospital, Victoria, B.C.

This textbook has been written for students at the university level. It is designed for those who are interested in studying a biological science whether or not they are involved in a biological field. The author assumes that the student has had a general high school background in chemistry and physics, and no background in biology. The first four chapters describe the general architecture, cells and tissues of the mammalian body together with a review of elementary chemistry.

The central theme of the book is based on the concept of homeostasis. Homeostasis is "the maintenance of a near uniform internal environment." The imperativeness of homeostasis is well illustrated in discussions of the various organs and systems of the body. Deviations from the normal and the various implications are satisfactorily described. The main objective is to show the student how dependent each organ is on a constant environment and how, in turn, each organ contributes to maintaining this constant environment.

The author writes with remarkable clarity. His verbal analogies are very apt and produce vivid explanations. His definitions are short but complete and easily understood. He includes a minimum of the anatomy of each system to make the physiology meaningful. The book follows a logical sequence. Although, of necessity, the author deals with each system separately, the final outcome achieves the purpose of guiding the reader into realization of various concepts. The student can see how certain organs and systems work as an integrated whole to provide the cells with nourishment, while other organs provide for excretion of various waste products. The balances obtained in this exchange provide a constant environment.

The author describes the effects of deviation from normal functions in different organs and tissues and how this is manifested in the body as edema, paralysis, hypertension, shock, etc. These concepts are not new but they are well stated and are in tune with his central theme. His discussions of shock, hypoxia, diabetes, hormonal control and kidney function are excellent. Some sections are quite involved and would require a good deal of interpretation to a junior student.

However, it is a book of principles. It is a pleasure to read. Throughout there is a natural logical sequence, delightfully simple style and remarkable clarity. It is beautifully integrated. It would be most suitable as a reference book in a nursing library or in a nurse's personal collection. The anatomy requirements necessary for an understanding of the physiological principles must be drawn from other sources.

Pediatric Surgery for Nurses by Edward G. Stanley-Brown, M.D. 172 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 1961. Price $5.00.
Reviewed by Mrs. Marjorie Blewett, Residence Director, Ellis Hall, University Hospital, Saskatoon, Sask.

The objective of the author is to satisfy the need for a source book on pediatric surgery written especially for nurses. The basic principles emphasized are those that apply to any area of pediatric nursing although the focus is on surgery. The excellent material in this text is presented in such a way that one almost instantly identifies with the author in his love for children and their appeal.

The psychological preparation of children for surgery is discussed in practical terms for the various age groups. The use of the rocking chair for the infant, the presence of the separation fear in the toddler, the age of reason in the pre-school and school-age child are simple examples of the factors mentioned. The all-important relationship between the nurse and the child as the most crucial element in the recovery of the child from surgery is presented in a realistic manner. The often neglected nurse-parent relationship is particularly well handled.

The common pediatric surgical disorders are discussed with excellent illustrations where necessary demonstrating the disorders, treatments and results. The fluid and electrolyte balance of infants and children, essential to successful surgery, is dealt with from the viewpoint of the nurse.

This book would be an excellent reference for the pediatric nursing student giving her a comprehensive picture of the "child surgical patient." For the teacher, it inte-

grates sound material that previously had to be secured from several different sources.

Most of the new material has increased the value of this book definitely and I feel that it is an excellent reference for instructors and as an addition to any student library.

Pediatric Nursing by Dorothy R. Marlow, R.N., Ed.D. and Gladys Sellew, R.N., Ph.D. 750 pages. W. B. Saunders Company, 3207 West Washington Square, Philadelphia. 1961.

Reviewed by Miss C. Pilley, Pediatrics Department, St. Mary's Hospital, Lacombe Ave., Montreal.

During the last few years the pediatric nurse has evolved as a person who assists the mother to give good care to her child, both when he is well and when he is sick. She thinks of her patient as a member of a family and an individual with feelings and emotions. She is no longer simply taking the mother's place by caring for her child when he is ill.

This new aspect of child nursing is presented in an excellent manner. Not every childhood disease is included because the emphasis is placed more on the psychological approach and on the growth and development of the normal child.

The book opens with a brief history of child care through the ages; a resumé of the growth and development of children; a summary of the role of the pediatric nurse; a consideration of the child when sick and hospitalized. The remainder of the book is divided into units dealing with the various age groups, from the neonatal period through to adolescence. Each unit gives a picture of the healthy child in a particular age group. A very accurate description is presented of the behavior, growth and development of the specific period, as well as the care of the normal child.

After the student has received a good picture of the normal child, the authors present the diseases most common to various age groups and their effects. The material is divided into those diseases requiring long-term care and those requiring short-term care. The picture of the healthy child provides a background for the management of the same child when he is sick. The way in in which the diseases are classified provides a basis for the management of individual conditions.

The authors help the nurse to view the sick child through the eyes of his parents as well as through her own eyes. She is helped to understand how she can help the

mother as well as her child. This should be a very important part of the work of the pediatric nurse.

The subject matter is presented in an interesting manner using simple language. This text would be of great value to the student and also to the more experienced pediatric nurse who is certain to gain much new knowledge and to broaden her outlook in her profession.

Basic Nursing Education Programmes: a guide to their planning by Katharine Lyman. 81 pages. World Health Organization: Public Health Papers, Palais des Nations, Geneva. 1961. Price $1.00 (Also published in French).

Reviewed by Mrs. Beverly Du Gas, associate director, Nursing Education, Vancouver General Hospital, Vancouver, B.C.

This book is primarily designed for the nursing educator working with the World Health Organization in countries where modern nursing and preparation for it are just beginning to develop. The suggestions for planning an educational program are, however, equally applicable for nursing educators in countries where nursing and nursing education are highly developed. This book should be a guide for any school of nursing faculty that is contemplating changes in the curriculum or is engaged in self-evaluation.

The first section deals with the analysis of community needs and community resources as a basis for planning nursing education programs. The areas suggested for study are pertinent to our Canadian schools of nursing. We should assess whether our programs are tailored to fit the needs of our respective communities and whether we are utilizing available resources to the fullest extent. The second section is concerned with the planning process and is a particularly helpful guide for people writing or revising the philosophy and objectives of a school. This chapter gave more specific information and direct guidance on this subject than I have been able to find previously in any nursing literature.

The book covers all aspects of a nursing education program. It offers guidance on the selection and admission of students; the qualifications of teaching personnel; the general plan for a curriculum; personnel services for students and financing of nursing schools. All guidance is given simply, clearly and concisely. The material presented is factual, up-to-date and practical. This is a very worthwhile publication. It fills the need for a concise guide in planning nursing programs which nursing educators, hospital

administrators and post-basic students in nursing will find extremely valuable.

Mosby's Review of Practical Nursing. 344 pages. The C. V. Mosby Co., St. Louis, Mo. 3rd., 1961. Price $4.25.
Reviewed by Mrs. Irene Rice-Jones, senior instructress, School for Nursing Aides, 1321 — 6th Avenue, N.W., Calgary, Alta.

In the United States, as in Canada, the variation in concept of the role and function of the certified nursing aide or licensed practical nurse has made it difficult to prepare a text which will fulfil the needs of the student or graduate nursing assistant. The authors have attempted to meet this challenge.

Although the format of this excellent text remains essentially the same as the second edition, the content has been expanded and the printing improved. In addition to bringing the content and references up-to-date, the authors have added new sections, reorganized or rewritten some units,

and expanded existing units in an effort to conform to the increasing emphasis on these particular aspects of nursing care. Many new examination questions have been added and additional words are included in the glossary. It is interesting to note the inclusion of the basic principles of physics and chemistry and their implications in terms of nursing care. The presentation is clear and concise.

The authors have been successful in reaching their main objectives. They have kept pace with the changing pattern of practical nurse education and practice. They have prepared a text to serve as a reference and to keep practical nurses informed of the current trends. It should encourage both trainees and graduates to become more responsive participants in their own development.

The text should prove invaluable to the instructor, who will find many practical suggestions on organizing material and a guide to more effective methods of preparing examinations and presenting lectures.

Calderwood's Orthopedic Nursing by Carroll B. Larson, M.S., F.A.C.S. and Marjorie Gould, R.N., B.S., M.S. 547 pages. The C. V. Mosby Company, St. Louis, Mo. 5th ed. 1961. Price $6.50.
Reviewed by Mrs. Marjorie Fitzgerald, clinical instructor, St. Joseph's Hospital, Victoria, B.C.

This new edition has been revised to provide up-to-date information in the field of orthopedic nursing. The focus is on the role of nursing in the total care of the orthopedic patient. It is written in a language that students of all levels will comprehend, and is generously illustrated. The illustrations are very valuable in teaching and assisting the student to become acquainted with orthopedic equipment and its use.

The book is divided into 15 units, each dealing with one particular phase of orthopedic nursing. The first unit would have special value for nurses who have not had training in body mechanics and rehabilitative techniques. It shows the nurse how to handle her patient with greater ease, and teaches her how to use her body so that she will be less tired at the end of a day and less likely to injure herself from straining or lifting.

Rehabilitative measures produce rewarding results when proper instruction is given to the patient by the nurse who understands her job. However, the nurse must know how and what to teach to be successful. The

principles of traction are defined and explained simply, directly and completely. A high degree of skill and knowledge is necessary in order to give satisfactory nursing care in this field.

The nursing instructor will welcome the new content on cerebral palsy and metabolic disorders of bone; the new and revised guides for study; new information about nursing the patient in traction; as well as the discussion of congenital deformities and disease in children.

Knowledge gives us greater confidence and satisfaction in the care of the patient and we can improve our understanding only by study and experience. I would recommend this textbook to all nursing personnel since its content, if carefully studied, would assist in medical and surgical as well as orthopedic nursing.

Anatomy and Physiology by Diana Clifford Kimber, Carolyn E. Gray, A.M., Caroline E. Stackpole, M.A. and Lutie C. Leavell, M.A., M.S. 779 pages. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ontario. 1961. 14th ed. Price $6.95.

Reviewed by Miss Geraldine LaPointe, associate director of nursing education, Royal Inland Hospital, Kamloops, B.C.

One would not question the fact that knowledge of the principles of physiology as they apply to health and disease is necessary if a student is to have an understanding of disease processes. Although recent advances have been made in physiology and biochemistry, it is difficult to condense such information into one text. In this revised edition, the author has supplemented some of the more important areas, for example metabolism, with a fairly easy-to-understand presentation. However, the value of such detailed discussion is questionable if a book is being considered for student use.

The authors stated that what is needed for an understanding of anatomy and physiology is a study of one in terms of the other, or in terms of interlocking relationships, structure and functions. This has been done very well. The introduction at the beginning of each chapter makes one want to explore the material to follow. Diagrams are exceptionally good and enhance the material. The chapter on water, electrolyte and acid-base balance is not too clear. Although reference is made to hydrogen ion concentration, the author continues to interchange the terms acids, bases and ion controls, without actually defining the terms. I think this leads to some confusion on the part of the reader.

Other Publications

Accident Prevention — A Workers' Education Manual, 1961. Canadian Branch, International Labour Office, 202 Queen Street, Ottawa 4, 182 pages. Price 75 cents.

This manual deals with safety in industry. It is not a technical manual, but rather purports to explain why safety is important, by what methods it is promoted and what kinds of authorities, institutions and other organizations are responsible for promoting it.

The contents include: The problem of accidents during work; the origins of accident prevention; accident investigations and statistics; some principles of accident prevention, e.g. fire protection, machine guarding and their application; psychological and physiological aspects of accident prevention; propaganda, education, training; special categories of workers; industrial safety activities of governments, public authorities and private associations; international safety regulations; trade unions and workers and industrial safety.

Applied Mathematics for Nurses by George I. Sackheim, B.S., M.S., M.A. 189 pages. Brett-Macmillan Ltd., 32 Water St., S., Galt, Ont. 1961. Price $3.95.

This is a mathematics work-book for the student nurse who is studying pharmacology. The author concentrates on the use of one type of formula for a solution to all the problems in dosages or preparation of solutions that the nurse may encounter. He feels that such an approach is much less confusing for the student.

Practice tests are included covering all the problems in the various units.

New and Nonofficial Drugs. Evaluated by the Council on Drugs of the American Medical Association. 849 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1961. Price $4.00.

This is an annual publication "containing descriptions of drugs evaluated on the basis of available laboratory and clinical evidence." The agents discussed may or may not have had their usefulness definitely established.

The text provides a useful quick reference,

particularly as related to newer compounds. Older drugs are only mentioned as necessary to provide adequate information.

Behavior Patterns of Premature Infants, a Nursing Study by Eileen G. Hasselmeyer, R.N., M.A. 85 pages. Public Health Service Publication No. 840, 1961. Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price 50 cents.

While the importance of the nurse's role in the care of premature infants is well recognized, few well controlled studies have been made of specific techniques. The procedure investigated here consisted of providing continuous support to the back or sides of the premature baby, by means of a rolled diaper. While this support did not result in a more rapid weight gain, it appeared to provide for increased amounts of sleep and decreased amounts of vocal and bodily movements. Other findings: "premies" sleep 80 per cent of the time during the first week, 75 per cent by the sixth week; they cry only 10 per cent of the time; there is no evidence of movement about 70 per cent of the time.

Teacher's Manual for use with Food, Nutrition and Diet Therapy by Marie V. Krause, B.S., M.S. 43 pages. McAinsh and Company Limited, 1251 Yonge Street, Toronto 7. 3rd ed. 1961.

The teaching guide follows the organization of the text. It offers suggestions for presentation of material; research problems, and laboratory demonstrations.

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Graduate Nurses for 50-bed active General Hospital on main highway between Calgary & Edmonton. Salary $290 - $335 with semi-annual increments of $7.50. $10 salary differential for up to 3 years' experience. Apply: Mrs. E. Harvie, R.N. Matron, Lacombe Municipal Hospital, Lacombe, Alberta.

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Public Health Nurse for generalized program. Starting salary range from $3,420 - $3,960 depending on qualifications & experience. 5-day work wk., accumulative sick leave, pension plan, car provided for duty. Direct inquiries including qualifications to: Secretary-Treasurer, Grande Prairie Health Unit Board, 10235- 108 Avenue, Grande Prairie, Alberta.

NURSES fully qualified for 30-bed active treatment hospital. New hospital building & recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta.

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Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

General Duty Nurses for small active hospital. Salary $294 for unregistered Nurses in B.C. $312 registered with yearly increments. Nurses' home available. For further particulars write: The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

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General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $309 to $374 Pre-planned shift rotation, B.C. registration essential, 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

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General Duty Nurses for new 82-bed hospital in the Aluminum City. Registered $309 plus $15 differential, 2 years experience $324 plus $15 differential. Room & board available at $45, 40-hr. wk., 10 statutory holidays, 4-wk. annual vacation, superannuation & Medical Plan coverage. Fare advanced, if required. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $309 B.C. registered $324-$389. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn & Hudson Bay Glacier. Initial salary $324, maintenance $47.50, 40-hr. 5 day wk., 4-wk. vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $309-$374. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty & Operating Room Nurses for modern regional hospital in a very active community. Starting basic salary $309 for B.C. registered & $294 for non B.C. registered. Allowance made for qualifications & experience. RNABC personnel policies in effect. Planned rotation, rooms available in new nurses' residence at $26 per mo. Apply to: Director of Nursing, Prince George Regional Hospital, Prince George, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses $297 with regular increases; Unreg'd., $285. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $309 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital. Salary: B.C. registered $324, non B.C. registered $314 per mo. with annual increments. 40-hr. wk., 4-wk. vacation, 1½ day sick leave per mo. Lodging $11 per mo. Travel refunded from Vancouver after 6 mo. Apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Nurses (2 by June 1st, 1962) for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia.

MANITOBA

Registered Nurse for modern 20-bed hospital. Salary $305 per mo. with $5.00 increment every 6-mo. for 2 years then $10 annually for 2 years. 40-hr. wk., 3-wk. vacation after 1 year, maintenance $45. Application to: Matron, Memorial Hospital, Deloraine, Manitoba.

Registered Nurse required by The Glenboro Hospital. Starting salary $305 per mo., modern nurses' residence in hospital. Glenboro is situated on No. 2 Highway — 100 miles west of Winnipeg. Good religious, social, recreational & sporting facilities available. Address applications & enquiries to: Mr. S. A. Oleson, Box 190, **Glenboro, Manitoba.** Application forms & personnel policy booklet mailed on request.

Registered Nurses for 12-bed hospital in Lynn Lake, Manitoba. Salary $325 per mo. plus room & board. Group insurance, medical & hospital, pension plan available. For further particulars apply to: W. F. Clarke, Personnel Manager, Sherritt Gordon Mines Limited, Lynn Lake, Manitoba.

Registered Nurses (2) 25-bed hospital near Winnipeg. Salary $315 respectively, 40-hr. wk., vacation pay, 10 statutory holidays, room & board $45, $10 increment, yearly, Registered Nurse (1) with supervisory experience to assume duties of Director of Nursing, immediately, commencing salary $360. Apply to: Administrator, DeSalaberry Hospital District No. 27A, St. Pierre, Manitoba.

Registered Nurses for 165-bed hospital, Starting salary $285, Good personnel policies. Full orientation program. Apply: Nursing Service Officer, Victoria General Hospital, Winnipeg, Manitoba.

Registered Nurses for General Duty for 18-bed hospital. Salary $315 - $355 per mo., full maintenance available in hospital residence for $45 per mo., generous personnel policies. Apply: Administrator, Community Hospital, Reston, Manitoba.

NEWFOUNDLAND

Director of Nursing for a modern 45-bed hospital in Carbonear, Newfoundland. Duties to commence August 1st 1962, accommodation provided in modern residence. Salary scale $3,655-$3,980 per annum. Apply giving particulars to: Medical Superintendent, Carbonear Community Hospital, Carbonear, Nfld.

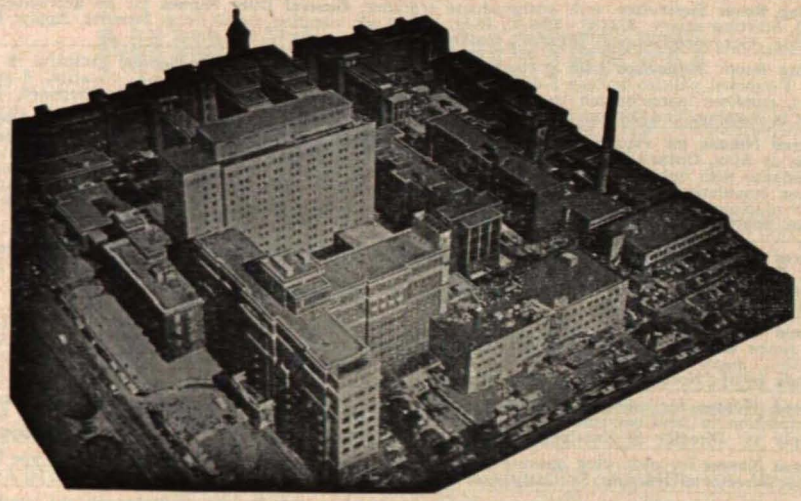
NOVA SCOTIA

Evening Supervisor for 50-bed General Hospital, 40-hr. wk., excellent personnel policies. Apply to: Director of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing (Immediately) for 86-bed hospital with planned extension to 126 beds, building to commence this year. Good personnel policies & furnished apt. in residence. Please apply by letter giving details of qualifications & experience to: Administrator, The Collingwood General & Marine Hospital, Collingwood, Ontario.



TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants
for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units
Rewarding Experience — Excellent Personnel Policies

For information write to:

Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

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GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

Operating Room Supervisor with postgraduate training, **General Duty Nurses** for an accredited 70-bed hospital. Starting salary: $280.80 - $296.40, 40-hr. wk., 3 wk. vacation, usual fringe benefits. Apply: Director of Nursing, Alexandra Hospital, Ingersoll, Ontario.

Operating Room Supervisor with postgraduate training, for 145-bed active General Hospital in Ottawa Valley. Personnel policies include 5-day wk., 60 days cumulative sick leave, 3-wk. vacation, 8 statutory holidays, employer participation in pension plan. Send applications to: Miss E. I. Sheppard, Reg. N. Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, **Ajax Ontario. Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario.

Registered Nurses for 86-bed General Hospital in French-speaking community in northern Ontario. Salary range $330-$360 per mo., 4-wk. vacation, 18 days paid sick leave, accommodation available in community, meals available in hospital if desired. Opportunity to learn French & English. For particulars apply: Notre-Dame Hospital, Hearst, Ontario.

Registered Nurses for immediate & future vacancies in this 42-bed hospital. Starting salary $320. Accommodation in new residence available. Pension plan & other benefits available. For full information apply to: Director of Nursing, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for new wing opening October, 1962. Excellent personnel policies & employee benefits. Apply to: Director of Nursing, St. Catharines General Hospital, St. Catharines, Ontario.

Registered Nurses. Applications & enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary & fringe benefits. Liberal policies regarding accommodation & vacation. Modern, well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur & north-west of White River. Pop. 2,700. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses for 60-bed hospital, starting salary $300 gross per mo., good personnel policies. Apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered Nurses for all services including Psychiatry & Operating Room. Salary range: $305 to $335 per mo. Personnel manual sent on request. Apply: Director of Nursing, The Wellesley Hospital, 160 Wellesley St. E., Toronto 5, Ontario.

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $320, maximum $370, 28-day vacation after 1 yr. C.N.A. minimum salary $232, maximum $265, 2-wk. vacation after 1 yr., 3-wk. after 2yr. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty Staff & Operating Room for 73-bed General Hospital located on beautiful Lake of the Woods. Apply to: Sister Edward Andrew, Treasurer, Saint Joseph's Hospital, Kenora, Ontario. — Telephone HO. 8-9836.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $385 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. **Assistance with** transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 miles north of Sault Ste. Marie, Ontario. Starting salary $310 min. to $360 max., less $20 per mo. maintenance. Recognition for experience up to 3 years. Good accommodations & personnel policies. Transportation allowance after 6-mo. **Operating Room Nurse** starting salary $364 min. with postgraduate course to $414 max. with recognition for experience. Apply: Superintendent of Nurses, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered General Duty Nurses (immediately) for new modern 35-bed hospital located in Almonte, 30-mi. from Ottawa. Good personnel policies. Apply to: The Director of Nursing Service, General Hospital, Almonte, Ontario.

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

General Staff Nurse for 163-bed Tuberculosis Sanatorium. Good personnel policies, residence accommodation available. Apply: Director of Nursing, Sudbury & Algoma Sanatorium, Sudbury, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital. Registered start at $300 monthly, Graduates $250 - $285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. **Male Nurse,** graduate or registered also needed. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed modern hospital, south western Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses (coming vacancies) in nearly all areas including the Operating Room, intensive Orientation program, on-going In-service program. Apply: Director of Nursing, **THE HOSPITAL FOR SICK CHILDREN,** 555 University Avenue, Toronto 2, Ontario.

Staff Nurses for 350-bed General Hospital located in downtown Toronto, rotating hours of duty, attractive personnel policies, planned orientation & in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Operating Room Nurse (experienced) for 100-bed General Hospital. Salary $350, room & board, if desired, $50 per mo., good personnel policies & O.H.A. Pension Plan in effect. For further particulars apply: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario.

Operating Room Nurse for small-sized hospital, good personnel policies & salary. Apply to: Superintendent, Kemptville District Hospital, Kemptville, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (qualified) for generalized program, minimum salary $3,900, allowance for experience, car allowance, pension plan, hospitalization & Windsor Medicall available. Apply, stating experience, qualifications & references, to: T. M. S. Kingston, Secretary, Chatham Board of Health, Chatham, Ontario.

Public Health Nurse (Qualified) for the Kent County Health Unit — generalized program. Starting salary: $3,900; salary schedule; allowance for experience; pension plan. 1-mo. vacation. Car & uniform allowance. Direct inquiries to: Sherman Brown, Secretary-Treasurer, Kent County Board of Health, 21 Seventh St., Chatham, Ontario.

Public Health Nurses (qualified) Salary $3,900 - $4,875, annual increment $195. Transportation provided, usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

Public Health Nurses (qualified) for generalized program with City of Peterborough. Personnel policies available on request. Apply to: J. R. Anderson, M.D., D.P.H. Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurse (qualified) for generalized program. Car expense allowance, pension, group insurance, hospitalization, Blue Cross & P.S.I. 50% paid by Board. Salary according to experience. Apply to: Dr. G. L. Anderson, Director, The Lambton Health Unit, 260 N. Christina Street, Sarnia, Ontario.

Public Health Nurses (qualified) for generalized program. Salary $3,720 - $4,520 (more in rural areas). Cars provided, pension plan, sick leave, other benefits. Apply to: Mrs. Muriel McAvoy, Secretary-Treasurer, Porcupine Health Unit, 70 Balsam Street South, Timmins, Ontario.

Pubic Health Nurse required by City of Waterloo, duties to commence September 1962. Personnel policies on request. Apply: Dr. P. A. Voelker, Medical Officer of Health, 36 Young Street West, Waterloo, Ontario.

Nurse with certificate in Public Health Nursing for Stormont, Dundas & Glengarry Health Unit in the Seaway Valley area. Generalized program. Min. salary $3,700 with allowance for experience up to the maximum. Annual increment, transportation allowance, attractive personnel policies which include 3-wk. vacation, pension plan, group insurance, hospital insurance with employer paying 50% of the cost. Apply in writing giving qualifications & experience to: Miss Glenna French, Supervisor, Public Health Nursing, Box 1058, Cornwall, Ontario.

BERMUDA

Instructor to be responsible for Nursing Assistant program. For full information, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £50-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Operating Room Supervisor for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary $300 per mo., salary increased as recommended by ANPQ, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

SASKATCHEWAN

Registered or Graduate Nurses (2) immediately for new 14-bed hospital. Salary, increments & sick leave according to SRNA, 40-hr. wk., accommodation available in residence. Apply: Mrs. A. E. Eye, Matron, Union Hospital, Hudson Bay, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses Career satisfaction, interest & professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational & cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! **Staff Nurse** entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area & shift differentials paid. Excellent benefits including Blue Cross hospitalization & surgical coverage & liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for completely modern 299-bed hospital. Starting salary $345 per mo., 40-hr. wk., $20 differential for P.M. shift; $10 differential for night shift. Additional $10 differential paid for obstetrics, nursery, operating room & psychiatric services. 7 paid holidays, paid sick leave, paid health & life insurance, liberal vacations, free employee parking, low cost cafeteria. Please write: Mrs. Dorotha L. Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses for 350-bed hospital, modern, all air conditioned new wing recently opened. Excellent salary with regular increments, differential for evenings & nights. Near beach & mountain resorts, nearby State College offers educational opportunities. For more information inquire: Director, Nursing Service, St. Mary's Hospital, 509 E. 10th Street, Long Beach, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves., nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses (Immediate openings in California) Expansion of our General Hospital has enabled us to offer excellent opportunities in all occupational specialities. Starting salaries: General Duty $390 per mo. days, $415 per mo. P.M.'s & Nights, $10 differential per mo. for psychiatry. Operating Room $415 per mo. days, $440 per mo. P.M.'s. Liberal employment benefits. The best in working conditions. Write: Personnel Dept., Sutter Community Hospitals, 2820 "L" Streets, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $355 - $435, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses (Work where it is fun to live! come to sunny California) for 274-bed hospital, located within walking distance of the beaches & a few minutes drive from Beverly Hills, Hollywood, & Los Angeles. (Salary according to prevalent range in area) outstanding fringe benefits (near excellent educational facilities.) Let us tell you more about the opportunities to give patient-centered care. Contact office of: Director of Nursing, Santa Monica Hospital, 1250-16th Street, Santa Monica, California.

Registered, General Duty & Operating Room Nurses for modern 74-bed District Hospital, midway between San Francisco & Los Angeles, California. Starting salary $350 per mo., 40-hr. wk., living quarters available. Contact: Administrator, Tulare District Hospital, 869 Cherry Avenue, Tulare, California.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per mo., day duty $419-$438; P.M. & night duty $429-$448, 40-hr. wk., paid vacation, 7 paid holidays per year, accumulative sick time based on length of service, liberal hospitalization plan, nurses' residence, rooms at reasonable rates. Registration or Permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco 17, California.

Graduate Nurse, Staff Duty for 100-bed acute County Hospital J.C.A.H. accredited, located in San Joaquin Valley midway between San Francisco & Los Angeles, 40-hr. work wk., sick leave, 3-wk. paid vacation, 12 holidays, a career employment, salary $358 - $415 depending on experience & recommendations, plus shift differential, rooms available in modern nurses' residence at $10 per mo., within 2 hours drive of ocean, mountain or desert resort areas. Write, wire or phone: Director of Nursing, County Hospital, Tulare, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 200-bed General Hospital in the heart of Los Angeles cultural & educational center. General Duty $360 per mo., min. days; $35 differential for 3-11 & $30 differential for 11-7. Time and ½ over 40-hr. wk., Social security, State disability insurance, 2 wks. vacation end of 1 yr., 3 wks. after 5 yrs., 7 paid holidays, 12-day sick leave. Cotton uniforms laundered, nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever possible. Apply: Mary Topper, R.N., Director of Nurses, Santa Fe Hospital, 610 South St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.

Registered Nurses for 78-bed accredited hospital in friendly coastal city with pleasant climate. Do not rotate shifts. 40-hr. wk. **General Duty** — $365 basic salary, $20 differential for 3-11 or 11-7 shifts. **Experienced Operating Room Nurse.** Basic salary $375 with financial reimbursement for calls. **Obs. Nurses** — $375 basic salary, nurses' residence available at reasonable rates. Apply: Director of Nursing, General Hospital Eureka, California.

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases & fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado.

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications for the positions of

(a) ASSISTANT DIRECTOR OF NURSING EDUCATION

(b) ASSISTANT DIRECTOR OF NURSING SERVICE

SALARIES COMMENSURATE WITH QUALIFICATIONS AND EXPERIENCE

Apply to:

DIRECTOR OF NURSING

GENERAL HOSPITAL OF PORT ARTHUR

PORT ARTHUR, ONTARIO

NANAIMO REGIONAL GENERAL HOSPITAL
NANAIMO, B.C.

requires

Supervisor
for Operating Room.

Head Nurses
for Pediatrics, Medicine, Surgery.

General Duty Nurses
for Operating Room, Obstetrics, Medicine, Surgery & Emergency Depts.

Salary: General Duty R.N. $309 to $374
Head Nurses R.N. $340 to $411
Supervisor R.N. $357 to $431

Allowance for experience and postgraduate education. Personnel policies in accordance with R.N.A.B.C. includes statutory holidays, 20 days vacation, sick leave, medical plan and pension fund.

New 188-bed hospital opening during October in Nanaimo on beautiful Vancouver Island, B.C.

Positions available September 15th.

Apply to:

DIRECTOR OF NURSING
NANAIMO REGIONAL GENERAL HOSPITAL
NANAIMO, B.C.

Applications are invited for the position of

ASSISTANT DIRECTOR OF NURSING RESEARCH

at

THE HOSPITAL FOR SICK CHILDREN, TORONTO

The Department of Nursing has received a grant to undertake a program of Nursing Research. This program is to be geared to improving patient care.

Applicants must have some experience with research methods and preferably experience in Pediatric Nursing.

Please address application to the:

Director of Nursing
The Hospital for Sick Children
Toronto, Ontario

Graduate Nurses (Professional) Choose a career at Chicago's renowned medical-teaching center. Various staff & special assignments available to provide a work setting compatible with your interests & experience. Starting salary to $420 per mo., plus $40 evening differential & premiums for special assignments. Fringe benefits include vacation to 4-wk. per year, 8 paid holidays, cumulative sick leave, Blue Cross & pension plan, private rooms in modern residence building. Your inquiries are invited: Director, Nursing Service, Dept. C.J.N., Mount Sinai Hospital, 2750 W. 15th Place, Chicago 8, Illinois.

Obstetrical Supervisor for 30-bed brand new O.B. Dep't. in 200-bed hospital. Responsible for supervision & coordination of nursing care of separately staffed Labor & Delivery Nursery & Post-Partum areas, facilities include Post-Partum Recovery Room & Rooming-in Units, prefer B.S. in Maternal & Child Health or P.G. in Obstetrics with previous supervisory experience. Salary commensurate with qualifications. Write: Director of Nursing, Highland Park Hospital, 718 Glenview Avenue, Highland Park, Illinois.

Registered Nurses for 200-bed General Hospital located in beautiful suburban residential area on Lake Michigan, 30-min. from Chicago. Base salary $380, differential of $20 for nights, $30 for evenings. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago. Recent completion of new building creates opportunities in all clinical services, liberal personnel benefits include free retirement program. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Operating Room Nurses for modern 200-bed General Hospital along the shores of Lake Michigan, 30-min. from Chicago. Progressive salaries and policies. Live in modern nurses' bungalows adjacent to hospital & enjoy social, cultural & educational advantages of Chicago, 6-room brand new operating suite, utilizing most current "nurse saving" methods & equipment. If you're a confirmed OR nurse you'll be right at home in our OR! If you feel you might be interested in OR (but aren't sure) our OR will convert you, beyond any doubt. Contact: Director of Nursing, Highland Park Hospital, Highland Park, Illinois.

Registered Nurses (Immediate full-time openings) Obstetrics, Medical, Surgical. Starting salary $400-$420, generous benefits. Apply: Personnel Department, Lake Forest Hospital, Lake Forest, Illinois.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s.; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth Hewitt, R.N., Director of Nurses, Chelsea Memorial Hospital, Chelsea, Mass.

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Obstetrical Supervisor responsible for the administration of the Obstetrical Department, for 575-bed hospital, salary $5,100 with increases to $5,460. New $3,500,000 building to open in fall. Entirely new modern Obstetrical Department in new building. Hospital has a large school with large faculty. Obstetrical Instructor carries the responsibility for teaching obstetrical nursing & supervision of students. Obstetrical supervisor assists with orientation & supervision of students. School of nursing has full accreditation with NLN. Retirement plan in addition to Social Security, hospital pays 5% of salary into fund & employee pays 3%. After 5 years, hospital provides life insurance policy for employee equivalent to one year's salary, hospital pays the policy, other liberal personnel policies, attractive working conditions, each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension centres or extension courses. Qualifications: Baccalaureate degree with preparation or experience in obstetrical nursing. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Science Instructor to teach Chemistry & Microbiology for 575-bed hospital with a $3,500,000 building ready to open in fall. Teaching & laboratory facilities excellent. School has full accreditation from NLN. There are 25 Nurse Instructors on faculty. Salary for assistant instructor $4,500-$4,860 with opportunity for promotion to full instructor in Science Department. Lectures given by Albright College Professor. School has 2 nurse instructors to teach the laboratory portion of the course. One class a year admitted. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions, each room in nurses' residence has its own private bath & shower, hospital located in a beautiful 40-acre park, community has many cultural opportunities, one college in city, 4 universities have extension center or extension courses in city. Qualifications: Licensed Nurse with Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

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Qualified Public Health Nurses for generalized Public Health Nursing Service. Salary range $4,108 - $4,647. Starting salary based on experience. Annual increments, vacation, shared hospital and medical insurance, sick pay and pension plan.

Apply: Personnel Department,
ROOM 320, CITY HALL,
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for

Royal Inland Hospital, Kamloops, B.C.

School of Nursing with 75 students, expanding to 100 with completion of new building in near future. Salary commensurate with preparation and experience. Superannuation and Medical plans in effect. Position open — September 1st, 1962.

Please apply to:
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Assistant Nursing Arts Instructor — 5 other full-time instructors with no administrative responsibilities. For 575-bed hospital & opening a $3,500,000 building in fall. Salary $4,500 with increases to $4,860 & opportunity for promotion with salary to $5,460. Two intensive care units in new building. School has full accreditation from NLN. There are 25 nurse instructors, Sciences taught by Albright College. Retirement plan in addition to Social Security, hospital provides a life insurance policy for employee equivalent to one year's salary, hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Clinical Instructor to teach a portion of Medical & Surgical Nursing, for 575-bed hospital with a new $3,500,000 building ready to open in the fall. Salary for faculty with no previous teaching experience $4,860 with increases to $5,460. Starting salary $5,100 for qualified instructors with 2 years' teaching experience. School of Nursing enlarging, increasing size of faculty. 12 full-time Medical & Surgical instructors with no administrative responsibilities. Also 2 full-time Dietician instructors in the Clinical area. Two intensive care units in new building, school has full accreditation from NLN. There are 25 Nurse Instructors. Sciences taught by Albright College. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Evening Clinical Instructor to work with the students in the clinical area from 3:00 to 11:00 P.M. for 575-bed hospital with a $3,500,000 building ready to open in the fall, 2 intensive care units are in new building. School has full accreditation from NLN. There are 25 Nurse Instructors. Sciences taught by Albright College. Starting salary for instructor with no previous teaching experience $4,980, increases up to $5,580, Instructors with previous teaching experience start at $5,220. The school has 10 full-time Medical & Surgical Instructors on days. Also a full-time Dietician Instructor in the clinical area. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years hospital provides a life insurance policy for employee equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. One college in city, 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Pediatric Instructor to teach a portion of pediatric nursing. 2 **Pediatric Instructors** for 575-bed hospital opening a new $3,500,000 building in the fall. Starting salary for instructor with no previous teaching experience is $4,860 with increases to $5,460. Instructors with previous teaching experience start at $5,100. School of Nursing enlarging & increasing the size of the faculty. School has 25 Nurse Instructors with no administrative responsibilities. Sciences taught by Albright College Professors. Entirely new & modern Pediatric Department in new building. School has full accreditation from NLN. Retirement plan in addition to Social Security. Hospital pays 5% of salary into fund & employee pays 3%. After 5 years the hospital provides a life insurance policy for employees equivalent to one year's salary. Hospital pays the policy. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath & shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities, one college in city, 4 universities have extension centers or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Penna.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies incude sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

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(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

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DIRECTOR, SCHOOL OF NURSING
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UNIVERSITY OF BRITISH COLUMBIA

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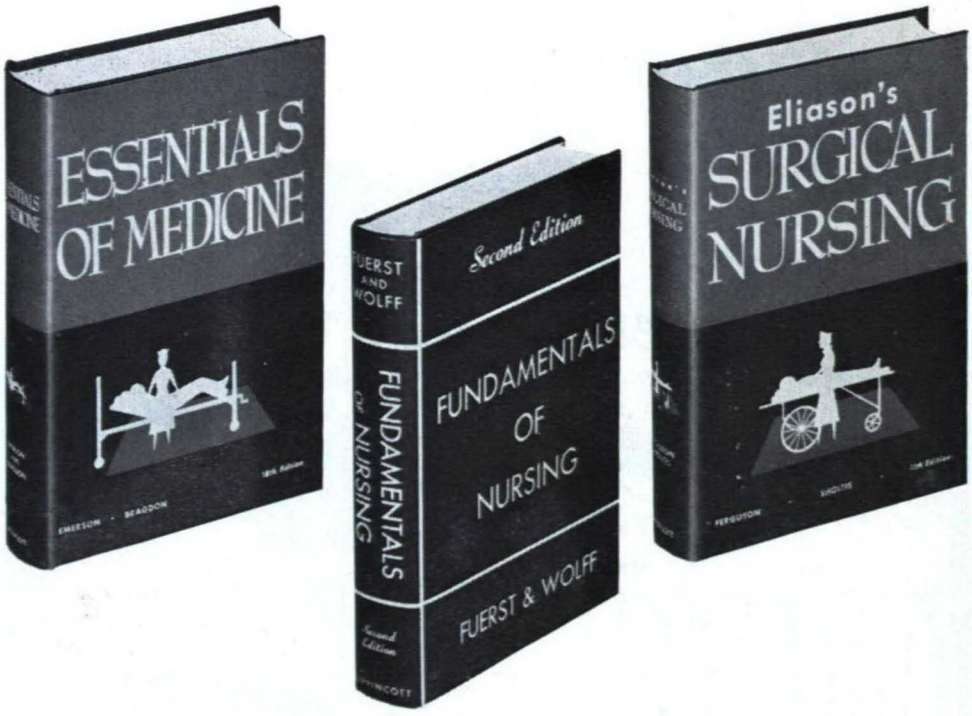

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Nourished by the fertile ground of principles, the content of nursing branches out — covering an ever-widening area. An orderly growth in the accumulation of *facts* depends on the *principles*, and the student, naturally, relies on both. These texts, sacrificing nothing in dependability in achieving popularity, offer the "why" and "what" that underlie knowledge with which the student can gain the self-confidence that permits insight in meeting problems of patient care.

ESSENTIALS OF MEDICINE: The Art and Science of Medical Nursing. By CHARLES PHILLIPS EMERSON, JR., M.D. and JANE S. BRAGDON, R.N., B.S., M.ED. 18th Edition, 1959. 857 Pages. 225 Illustrations, 8 Plates in Color. $7.25.

SURGICAL NURSING: By L. KRAEER FERGUSON, M.D. and LILLIAN A. SHOLTIS, R.N., B.S., M.S. 11th Edition, 1959. 766 Pages. 331 Illustrations, 3 Plates in Color. $6.75.

FUNDAMENTALS OF NURSING: The Humanities and the Sciences in Nursing. By ELINOR V. FUERST, R.N., M.A. and LUVERNE WOLFF, R.N., M.A. 2nd Edition, 1959. 662 Pages. 148 Illustrations. $5.75.

ANNOUNCING: # 1 OF NURSING EDUCATION MONOGRAPH SERIES
NURSING OF ADULTS: A Plan for Teaching Care of Adults . . . $2.00
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